Canadian Hospital

Journal of The Canadian Hospital Association

September, 1960

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*Bogash, R. C.; DeLa Chapelle, N.; Sowinski, R., and Downes, D.: Disposable Type Vials for Adding Medications to Large Volume Parenterals, Am. J. Hosp. Pharm. 17:104 (Feb.) 1960.

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Canadian Hospital

THE JOURNAL OF THE CANADIAN HOSPITAL ASSOCIATION

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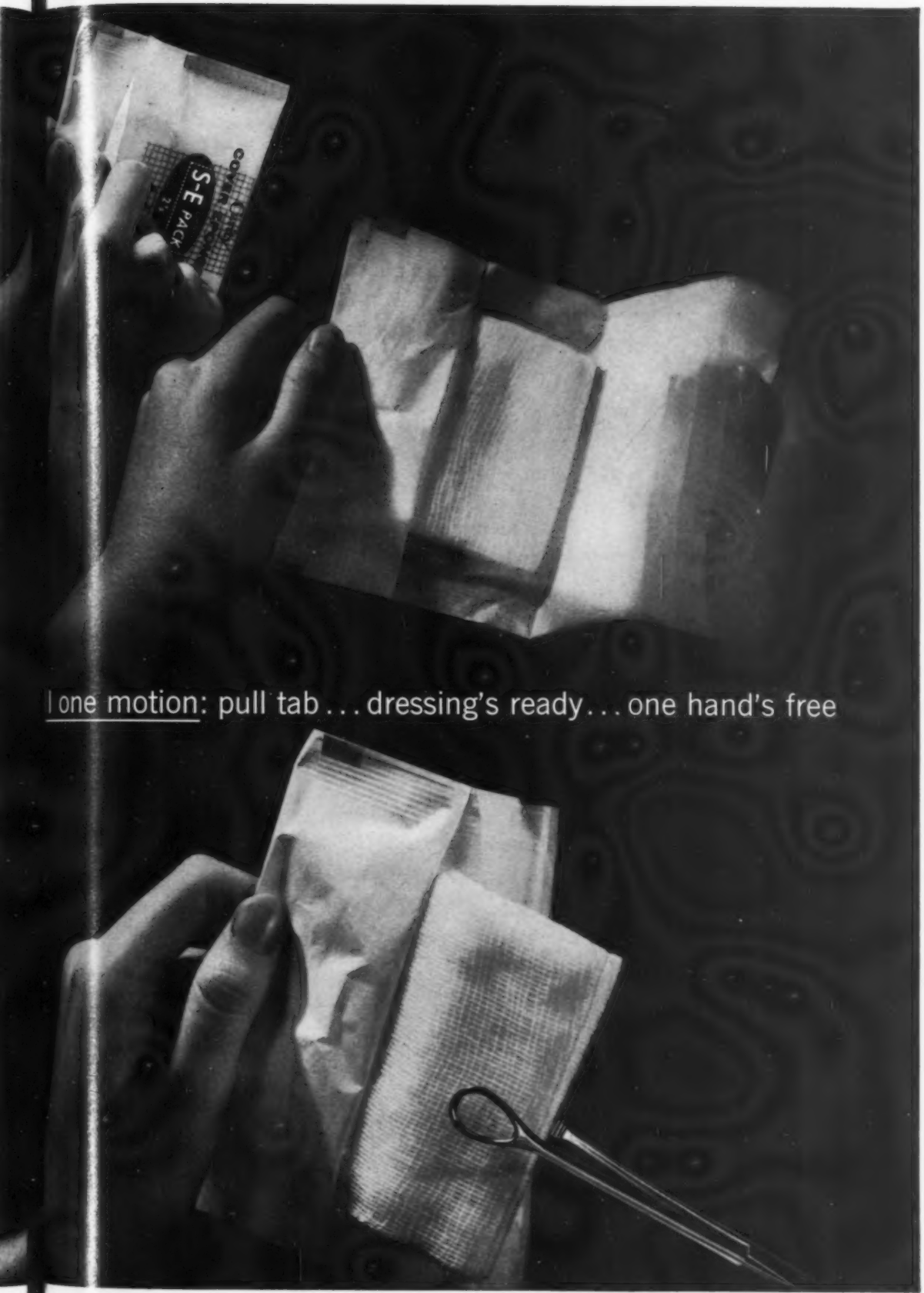
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one motion: pull tab . . . dressing's ready . . . one hand's free

7 ways to improve patient care and hospital efficiency

. . . through the functional use of communications and sound

Well-planned Executone sound-communication systems can perform heroic labors in the hospital. More than 30 different applications have been designed. Seven broad areas are detailed here. They are capable of lifting many burdens that high costs and personnel shortages impose on patients, administrators and staff.

1. Provide for instant command-response in surgery

Lives can be saved by immediate response to doctors' commands in the Surgical Suite. It is vital that a surgeon obtain assistance from remote departments with as much dispatch as he receives an instrument from his Operating Nurse. He may, for instance, have to suspend an operation until a report on a specimen can be obtained from Pathology . . . until Blood Bank or Sterile Surgical Supply can fill an unforeseen need.

Executone's intercom systems put these services at the surgeon's immediate disposal. They fulfill special requirements of the Operating Room—explosion-proofing . . . foot-operation . . . extremely well-modulated voice reproduction. They can, in addition, be used to transmit 2-way voice communication between the surgeon and students.

In other than surgical areas where urgent situations arise, action can almost always be expedited by properly-specified Executone communications.

2. Raise nurses' productivity; improve bed-patient care . . . in new and existing hospitals

Time and motion studies have proved that nurses' foot travel can be reduced by as much as 65%. At the same time, more duties can be assumed by orderlies, aides and Practical Nurses. The source of these skilled-labor-savings is the Executone audio-visual nurse call system. It can make a reduced nursing staff more responsive to the patients' needs.

In most cases, it can be installed using existing nurse call wiring. An effective audio-visual system will incorporate the following factors:

a. ability of patients, including those unable to move or speak normally, to use the system effortlessly.

b. operation of the system with all its advantages regardless of the location of nurses at any given moment, or the number of calls registered.

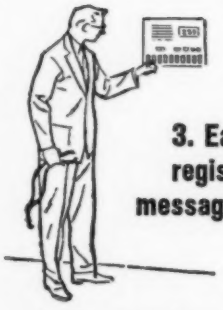
c. provisions to avoid a patient's being unable to signal.

d. psychological reassurances—of the proper registration of a patient's call, and the maintenance of his privacy.

e. foolproof, urgent-priority call registration from bathroom stations.

f. use of the system to monitor sounds in post-operative cases, polio or seclusion wards, nurseries, etc.

A demonstration of Executone's advanced nurse call equipment will show you how all these functions and safeguards can be implemented, and a system designed for any set of requirements.



3. Ease doctors' registration and message problems

In-out registration and message collection duties are so burdensome to doctors that many frequently neglect these essentials. Confusion and delays result. Executone, however, makes available a variety of systems designed to relieve this condition. One notable advance is Executone's simplified, one-stop register-and-message facility.

This facility is made available to the doctor at all habitually used entrances. Each register is tied in to a central compact "memory" unit at the hospital message center. The doctor need only push

his own 3-number code into the nearest register and indicate whether he is entering or leaving. This information is stored in the "memory" unit and is instantly available at any register. If there are messages for a doctor when he uses a register, a blinking light alerts him, and he may speak to the message center by 2-way intercom. The use of a central "memory" unit makes possible significant economies in wiring.

4. Increase the versatility of doctor-paging systems

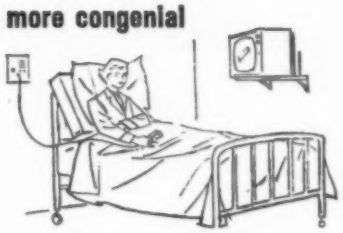
The paging facilities in today's hospital can offer a far greater range of service—thanks to Executone's multi-purpose systems. Not only does this equipment make possible a variety of interchangeable paging methods, but it will accommodate background music and alarm functions as well.

In addition to the conventional all-hospital page, the Executone-equipped paging center may use:

zoned paging. A sequence of zoned pages will usually locate a doctor without disturbing the entire hospital. A typical sequence might be: obstetrical suite . . . maternity ward . . . doctors' lounges and dining rooms.

localized paging. This system operates as above—with this exception: On floors or wards served by nurses' stations, paging is restricted to the duty area. The nurse completes the page by selective use of the nurse call system. This method gives maximum quiet in patient areas.

5. Make the hospital environment more congenial



Sound can be genuinely therapeutic. Leading administrators attach great importance to its use for diversion and entertainment. They favor the availability of music—in wards and labor rooms, for example, as well as waiting rooms and visitors' facilities. Chapel services can be transmitted to the rooms of patients who so desire.

Executone's versatile paging and nurse call systems readily handle these additional functions. For example, each patient can be supplied with an Executone Pillow Speaker and controls. This remarkably compact instrument is a high quality sound reproducer . . . radio station and TV channel selector . . . volume control . . . and nurse call cord set—all in one. No radios are needed in the rooms. Programs—and records or tapes—originate at a central control rack.

6. Speed internal action; keep telephone lines free

Reliance on the telephone for internal communication in the hospital often results in delay and switchboard congestion. Efficiency requires a channel of communication independent of the telephone . . . in order that administrators may have direct contact with heads of departments . . . that related departments be in instant touch with one another . . . that there be adequate intercom facilities within departments.

Executone's intercom systems have proved their worth in hundreds of hospitals — in terms of increased staff productivity, time savings, and freeing switchboards for rapid response to emergency calls.

7. Expedite out-patient, clinic and emergency service

Traffic can be made to flow smoothly, and doctors' time conserved, by effective communications in departments serving ambulatory patients. Emergency admissions, too, can be handled with efficiency . . . day and night.

Executone intercommunication — between nurses' stations and the medical facilities they serve — is the key to improved operation in these areas. An ambulance entrance which is not regularly staffed at night can be made functional around the clock—by the use of an outdoor Executone ambulance intercom station to summon proper personnel upon arrival of an emergency case.

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Notes About People

At St. John's Hospital for 50 Years

Dr. Norman S. Shenstone, an outstanding Toronto surgeon, has retired as chairman of the medical board of St. John's Convalescent Hospital, Newtonbrook, Ont., after 16 years in that position. He is succeeded by Dr. F. P. Dewar.

Reverend Sister Beatrice, former superintendent of the hospital, unveiled a portrait of Dr. Shenstone which was painted by the Canadian artist Cleeve Horne. Dr. Shenstone was presented with his portrait, and it will hang in the main entrance to the hospital. Dr. Shenstone has been associated with St. John's for the past 50 years and will continue as a member of the staff.

At the Toronto General

Mary E. Macfarland has retired as director of nursing at the Toronto General Hospital, Toronto, Ont., after 35 years of service. A 1926 graduate of the school of nursing of the Toronto General, Miss Macfarland won awards for general proficiency and practical work. The Jean I. Gunn scholarship was awarded to her in 1937 and she completed the course in teaching and supervision at the school of nursing, University of Toronto. In 1942 Miss Macfarland was appointed superintendent of nurses at the Toronto General, a title which was later changed to director of nursing.

Through her active membership in many professional organizations, Miss Macfarland has made valuable contributions to nursing. She is a life member of the alumnae associations of the school of nursing at the Toronto General and of the school of nursing at the University of Toronto. Also, she is a member of the advisory committee for the school of nursing, University of Western Ontario.

Margaret Jean Dodds is at present acting director of nursing. Also a graduate of the Toronto General, Miss Dodds took postgraduate study in nursing education at the University of Western Ontario. She has had much experience in supervision and teaching, as operating room supervisor and instructor 1951-58, and for the past two years as nursing service supervisor in the Central and Gerrard Street buildings at the Toronto General.

A newly-created position of assistant director, staff education, has been filled by E. Jean McKay. Another graduate of Toronto General, Miss McKay was, until recently, assistant director of nursing service at the hospital. Miss McKay in her new position will be responsible for organizing and directing the inservice program for professional and auxiliary nursing personnel.

Appointment of James A. McNab

James Alexander McNab, formerly the administrator of The General Hospital of Port Arthur, Ont., joined the staff of the Ontario Hospital Services Commission's Hospital Planning Division at the beginning of this month.

Mr. McNab received a Bachelor of Commerce degree from the University of B.C. in 1949, a diploma in Hospital Administration from the University of Toronto in 1951, and is a member of the American College of Hospital Administrators. Beginning his practical experience as administrative resident at the Vancouver General Hospital, Vancouver, B.C., he then served as Hospital Inspector and consultant with the B.C. Hospital Insurance Service for a period of three years. He was appointed administrator at Port Arthur in December, 1954.

James McNab

In addition to this full-time appointment Mr. McNab has, until now, assisted the Manitoba Hospital Services Plan as a member of a three-man Hospital Survey Board, and has been serving as a member of the resolutions committee of the Ontario Hospital Association.

Officers for the Maritime Hospital Association

Leo F. MacDonald of Charlottetown, P.E.I., was re-elected *president* at the 18th annual meeting of the Maritime Hospital Association held in St. Andrews, N.B. Other officers are: *vice-president* for N.B., and president of the N.B. Hospital Association, Chairman Abbis, Edmundston; *vice-president* for N.S., J. D. McClearn, Liverpool; *vice-president* for P.E.I., Neil MacLean, Charlottetown; *vice-president* for Newfoundland, Dr. A. W. Taylor, St. John's; *secretary-treasurer*, Mrs. Gladys M. Porter, Kentville. Other members of the executive are Mrs. Lois Gladney, Fredericton; Maurice Edwards, Wolfville; and Sr. Mary Fabian of St. John's, Newfoundland.

To Attend European Sessions

Dr. C. A. Morrell, head of the Food and Drug Directorate in the Department of National Health and Welfare, will be a speaker when the centenary of the British Pure Foods Law is celebrated in London, England, this month from the 19th to the 24th. This legislation represented the first general law of its kind at a national level. Representatives from the Commonwealth and the United States will attend the sessions. Dr. Morrell will trace the development of the Food and Drug Act in Canada since its inception in 1874. Following the London meeting Dr. Morrell will visit Europe to attend World Health Organization special sessions in Geneva and Copenhagen as a consultant.

Resignation of Dr. Lindsay

Dr. W. S. Lindsay has resigned from the position of assistant director (medical) at the University Hospital, Saskatoon, Sask. Since the inception of this hospital, Dr. Lindsay has been on the staff. On behalf of the University Hospital, Dr. Swanson announced that Dr. Lindsay will continue his association with the hospital as secretary to the University Hospital Board.

Dr. Donald Gee has replaced Dr.

(continued on page 22)

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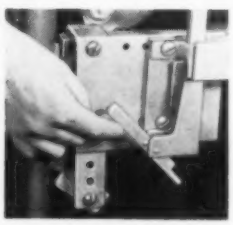

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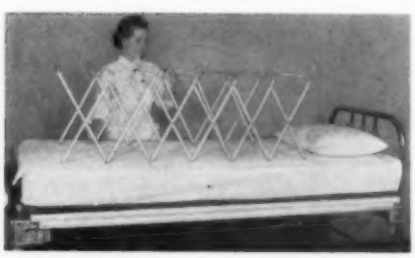

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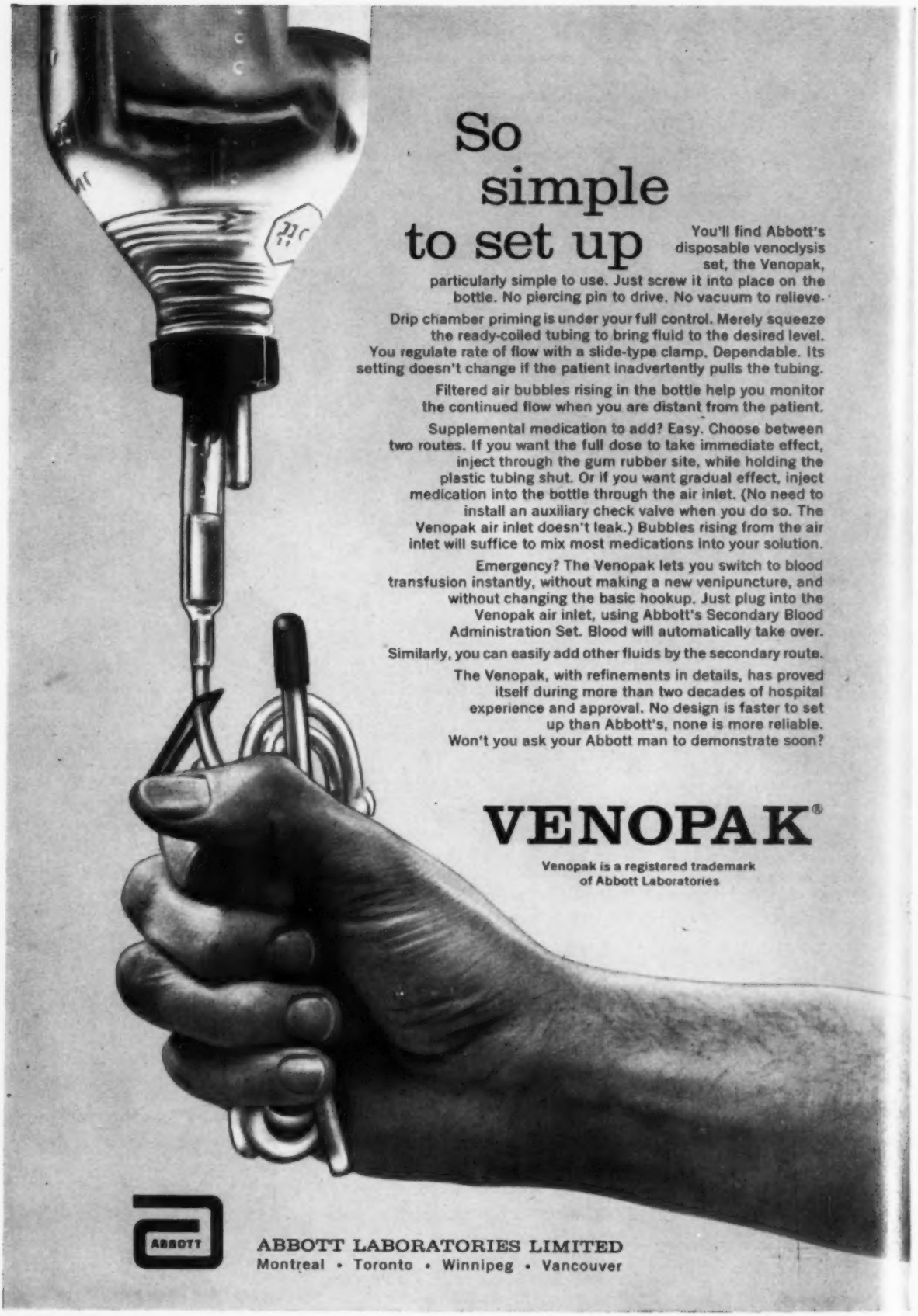
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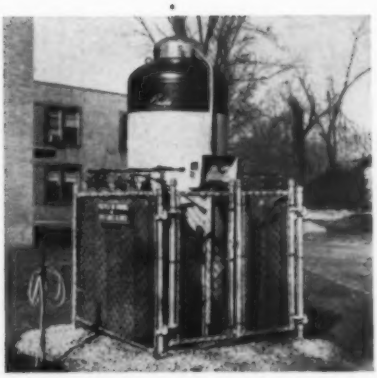
Surprisingly compact, this 90 VCC unit holds 90,000 cu. ft. of oxygen. It's a relatively small package because at atmospheric pressure liquid oxygen in its gaseous state would require 862 times more storage space.



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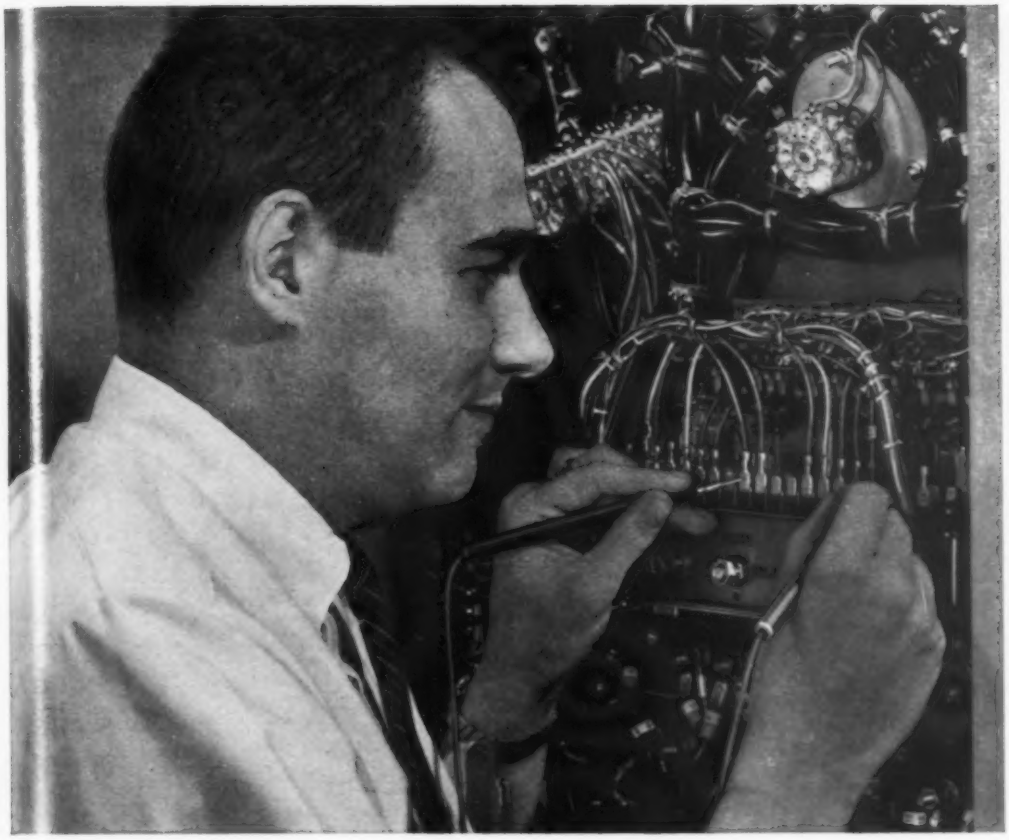

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People

(continued from page 12)

Lindsay as assistant director (medical). Recentiy Dr. Gee has taken a course in hospital administration at the University of Toronto.

Appointments at The Doctors Hospital

At The Doctors Hospital, Toronto, Ont., Madeleine Belzile of Edmundston, N.B., has been appointed chief dietitian. Prior to her appointment Miss Belzile was attached to the Department of Health and Social Service in the province of N.B.

Another appointment has been Dr. Phillip B. Callaghan of Melbourne, Australia, to the full-time position of intern co-ordinator. He was previously intern co-ordinator at the Colorado University Medical Center in Denver, Colo., for two years.

● Dr. Gibson E. Craig, a dermatologist on the staff of the Royal Victoria Hospital, Montreal, Que., since 1946, has been appointed dermatologist-in-charge, succeeding Dr. L. P. Ereaux.

C.F.A.P. Fellowship Award

Sr. Mary Columba, a hospital pharmacist with St. Joseph's Hospital, Toronto, Ont., has been named the fourth recipient of the Graduate Fellowship in Hospital Pharmacy offered annually, in the amount of $750.00, by the Canadian Foundation for the Advancement of Pharmacy to assist with a one-year internship in hospital pharmacy. Sr. Columba will take an internship at St. Mary's Hospital, St. Louis, Missouri, under the direction of Sr. Mary Berenice, chief pharmacist, for a year commencing Sept. 13, 1960.

At the Hospital for Sick Children

Dr. Alan W. Conn has been appointed anaesthetist-in-chief at the Hospital for Sick Children, Toronto, Ont., succeeding Dr. Ivan C. Junkin. Dr. Conn graduated in medicine from the University of Toronto in 1948 and is a Fellow of the Royal College of Physicians of Canada. After his internship at the Toronto Western Hospital he spent two years of study in Britain on a McLaughlin Travelling Fellowship. Dr. Junkin, who has resigned from this position, will remain on the hospital staff where he has specialized in paediatric anaesthesia for over 33 years.

Radiologist Honoured

Dr. E. A. Petrie of Saint John, N.B. has been appointed to the board of chancellors of the American College of Radiology. Director

(continued on page 30)


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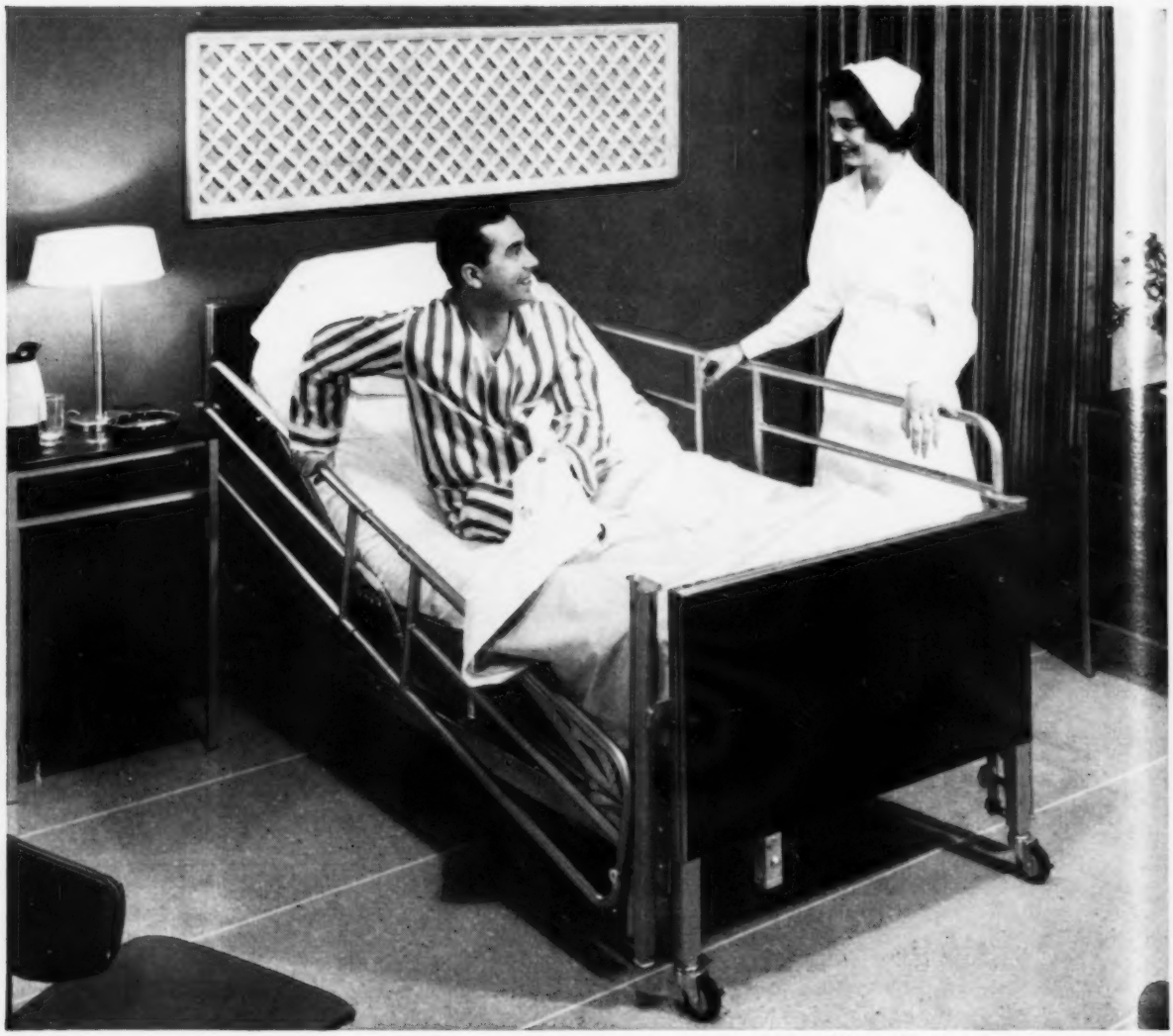

Safety Sides on Simmons H-346-3 Sim-matic Bed

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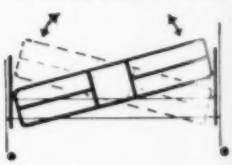
designed to fit every hospital bed



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Provide full or half side protection as desired! H-875 SAFETY SIDES used full length give complete patient protection. An efficient half-length model is obtained by lowering the foot end.

Sides can also be used by patients as an aid getting in and out of bed. The nurse can easily lower the head end for quick access to the patient. Completely lowered, sides cannot interfere with bed-making. For extra durability, H-875 Sides are cadmium plated. They attach to the brackets permanently fixed to the bed ends, and their telescopic design permits them to be used on all Simmons Bed lengths. The H-875 represents the one complete safety side for every hospital bed.

In the illustration H-875 Sides are shown on the *H-346-3 Sim-matic Bed* which has a six-button control switch. This permits the patient to adjust the head and foot ends of the posture spring, and raise and lower the bed.

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Reduces Cross Infection. Spray easily applied without touching patient...minimizes nurse-transfer of infection.

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Economical. Two applications daily afford ample protection from irritation. One can lasts for approximately 60 days.

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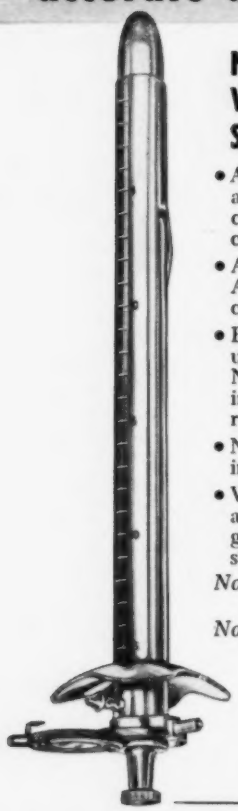
NEW YORK 10

Dependable WELCH ALLYN instruments speed accurate diagnosis and simplify hospital procedure



New, simpler Welch Allyn SIGMOIDOSCOPE

- All parts are sterilizable by autoclaving, even the light carrier, lamp and connecting cord.
- All parts are interchangeable. Any obturator or light carrier can be used with any speculum.
- Brilliant distal illumination of uniform spot type with WA No. 2 lamp projects light deep into cavity. Lamp is unusually rugged and long-lived.
- No specular reflection. Serrated interior eliminates glare.
- Vision is unobstructed. Lamp and light carrier are recessed, giving maximum space for instrumentation and observation.

No. 311, sigmoidoscope, 25 cm. length.

No. 312, proctoscope, 15 cm. length.

Unique Welch Allyn ROTATING ANOSCOPE

facilitates examination and instrumentation

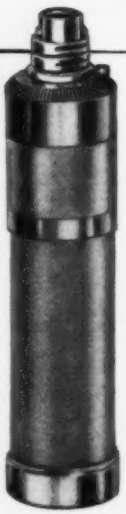
- Speculum can be rotated without moving handle. Simple gear mechanism turns speculum through full 360°
- Orbiculated edges minimize discomfort as speculum is rotated, even in the presence of rectal pathology.
- Entire instrument can be autoclaved or boiled, including the light carrier and lamp.
- Brilliant self-illumination with durable WA No. 2 lamp.
- Fits all standard WA handles, including new rechargeables.

No. 288, rotating anoscope, with light carrier.

Diagnosis is faster and easier with a Welch Allyn OPHTHALMOSCOPE

All the famous WA "oph" features are included, plus complete one-hand control of all functions, detachable rubber hood, extraneous light shield, removable condensing lens, and functional, modern design. Fits all WA handles.

No. 121, ophthalmoscope, with rubber hood.



End battery replacements

Newest Welch Allyn RECHARGEABLE HANDLE

- Fits all WA medium-handle set cases
- Provides satisfactory illumination longer between charges than standard medium batteries.
- No separate charger.
- Cannot corrode.
- Cannot overcharge.
- May be recharged thousands of times.
- Fits all WA instruments.

No. 717, Rechargeable battery handle.

No. 717-B, Extra bottom section.

Doctor's perennial favorite— Welch Allyn OTOSCOPE

The famous diagnostic otoscope so popular the world over. Brilliant illumination, very large magnifying lens, convenient lens frame design, durable, trouble-free construction. Fits all WA battery handles.

No. 201, diagnostic otoscope.

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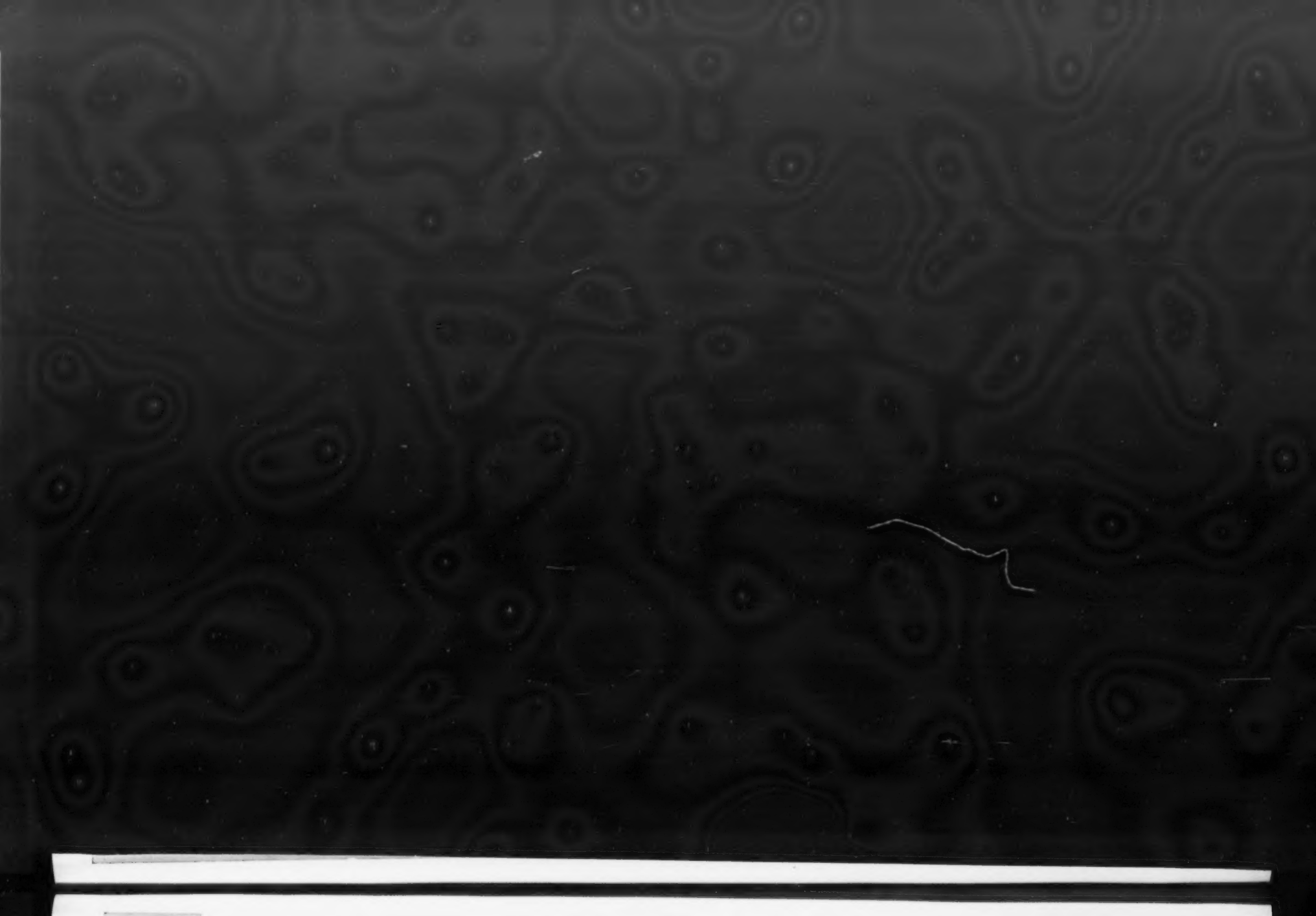


People

(continued from page 22)

of the x-ray department of St. Joseph's Hospital, Saint John, Dr. Petrie is a past president of the Canadian Association of Radiologists and is a director of the Canadian Society of Radiological Technicians.

New Appointments at Windsor

Recently there have been three appointments to the staff of the Essex County Sanatorium and I.O.D.E. Memorial Hospital, Windsor, Ont. Mrs. Ruby Dawe, who was previously at Stratford General Hospital, has been appointed purchasing agent. Judith Kirker, from New Zealand, and Rosita Lamson, from the Philippines, have joined the laboratory staff as technicians.

Agnes Macleod

Agnes Macleod, director of nursing services with the Veterans Affairs Department since 1945, died recently. Miss Macleod served as director of nursing education at the University of Alberta and at Vancouver General Hospital before joining the Royal Canadian Army Medical Corps in 1940. She headed several nursing detachments in England and Europe in the Second World War. She was wounded during the random shelling of a field hospital in Sicily.

B.C.H.I.S. Appointment

Jack Bainbridge, administrator at the Castlegar and District Hospital, Castlegar, B.C., has resigned from this position to accept a post as hospital consultant and inspector with the B.C. Hospital Insurance Service at Victoria.

Ontario Hospital Appointments

Dr. John G. White, a graduate of McMaster University, has been appointed assistant superintendent of the Ontario Hospital in Hamilton. He succeeds Dr. Barry Boyd, who has been appointed superintendent of the Ontario Hospital at Penetanguishene.

Quebec Hospital Insurance

January 1, 1961, has been set as the date for the inauguration of hospital insurance in Quebec. Dr. Jules Gilbert, Quebec, P.Q., hygiene expert and former president of the Canadian Association of Public Hygiene, has been appointed as director-general of the hospital insurance plan.

Appointment in Cardiology

Dr. Albert W. Lapin, associate physician at the Jewish General Hospital, Montreal, Que., has been appointed chief of clinical cardiology at that hospital. He succeeds Dr. Harold N. Segall, who has been appointed to the honorary consulting staff of the hospital. Dr. Lapin is a Fellow of the Royal College of Physicians of Canada, a member of the Royal College of Physicians of London, and a Diplomate of the American Board of Internal Medicine.

Medical Aid for Congo

Physicians chosen by the Canadian Red Cross for service in the Congo are Dr. John A. Davidson from Ormstown, Que., general practitioner; Dr. Philip A. Edwards from Dorian, Que., clinical parasitologist; Dr. Roger Paulin from Montreal, Que., thoracic surgeon; and Dr. Johnathan C. Sinclair from Toronto, Ont., internist.

• Dr. Ian W. Davidson recently left Sudbury, Ont., for Toronto to take up new duties as administrator of the Ontario Crippled Children's Rehabilitation Centre.

(continued on page 92)

Now!
Positive Control of Airborne Bacteria in Hospital Operating Rooms with the Honeywell Electronic Air Cleaner!

INTERNAL MEMO:

THE STANDARD ELECTRIC TIME COMPANY OF CANADA LTD. 103 GUN ST., POINTE CLAIRE, P.C

From: C. J. Pratt **Date:** Sept. 6/60

To: Advertising Agency

Subject: Sept. Issue Canadian Hospital

This issue carries a story on the new Brantford General Hospital. Here, once again, Standard has installed a complete fully automatic "Nurse Saver" nurse call system plus the Doctor Paging System. This paging system, incidentally, is our new, ultra-quiet "Whisper Paging" that is causing so much favourable comment wherever it is installed. Our advertisement should stress our continuing leadership in this area.

Regards

Jim P.

W. Douglas Piercey, M.D., Editor

Canadian Hospital

Obiter Dicta

Brantford General, 1885-1960

THERE is an element of romance in the origins of many of our older hospitals. The Brantford General, which is featured in the following pages, celebrates its 75th anniversary this year. In this connection a handsome booklet was compiled which tells, in one chapter, the quaint story of the first hospital's formal opening. Formal indeed, with a "gubernatorial special" arriving from Toronto on a freezing cold day in February. The guests included the Lieutenant Governor, His Hon. John Beverly Robinson, and his wife, together with a large number of other government and hospital officials. The guard of honour suffered many nipped ears and noses. A luncheon snack for the honoured guests lasted about two and a half hours. The hospital was opened with pomp and ceremony and in the speeches which lasted all afternoon is revealed the origin of the hospital.

A citizen of substantial means, John H. Stratford, Esq., realizing the need for such an institution in the area, generously bought a site and erected the hospital entirely at his own expense. It was larger and more complete than any the citizens had ever hoped to have and it was situated in seven acres of green pasture land. The pasture was not without a practical purpose —cows were kept to provide milk for the patients and sheep were also allowed to graze in order to save the expense of buying a lawn mower.

The hospital named for its founder, the John H. Stratford Hospital, "gleamed white and red in the bright sun, its gabled towers with their slim finials pointing prophetically upward, a symbol of hope and succour and healing . . ." Patients enjoyed a peaceful vista down to the "winding silver trail of the Grand River and beyond . . ."

John Stratford was known to his contemporaries as a very practical man (hence the cows); but some citizens today think he foresaw a future need for a very much larger hospital when he provided the terrace hill site. Be that as it may, the hospital of 1960 was a long way off and we'd be willing to bet he did not visualize a large section of the sheep pasture being used as a parking lot for 300 cars. Alas this is progress.—*J.F.*

Through the myriad eyes of others

THE administrator, in most cases, has a clear concept of his hospital, of its physical layout, the people who work there, the goals of the institution and its performance. He believes his patients are receiving good care. While, of necessity, there is suffering and at times sorrow within hospital walls, these are offset to some degree by the large percentage of patients who are assisted back to health and the many who are patched up and given another opportunity to resume their places in the community.

The hospital administrator believes in his institution. He has confidence in its work and, while realizing that as a human institution it is not perfect, he considers it is excellent. However, the wise administrator knows that the picture he sees is not necessarily that of the average citizen. It is not that of the members of the medical staff, the hospital personnel or the patients. The hospital they see and experience is something quite different.

Many administrators have tried to ascertain what the hospital's image is in the minds of others. Various methods have been developed in an attempt to find out what they think. (See page 70). Several large surveys which have been conducted portray an image which dismayed the administrators concerned.

The community's general image of the hospital may be blurred by indifference or it may be sharp. In the latter case the reaction may be good or bad. If bad, it may be the result of a number of small irritating episodes. These are the ones that are remembered and talked about over a cup of coffee or the bridge table. They are not offset because Mrs. Jones' triplets, born prematurely, were saved

by the knowledge of the medical staff, the care and devotion of the nurses or the costly technical apparatus which was available when needed. It is the petty annoyances which tend to distort the true image.

The administrator wants his community to see his hospital in as good a light as he sees it. To sharpen the image in the eyes of the community requires action and this must be continuous rather than sporadic. As in any successful operation there must be a plan of action. It is equally apparent that no one person can achieve good personnel relations either. We must enlist the support of everyone connected with the hospital and no segment can be overlooked.

Some hospitals conduct their public relations programs in spasms only—when a board member, or the women's auxiliary, get enthusiastic. Perhaps a building campaign sparks activity and for a time the community is deluged with press releases, T.V. and radio programs. These media are enlisted in support of the objective but, when this is reached, the public relations program withers like a plant in dry soil. All is silence and the community hears nothing further until the next campaign.

In maintaining a continuing public relations program the administrator will be alert to the many misconceptions about his institution and he will substitute facts for fiction. He should be aware of the petty grievances and do something about them. A frequent complaint of patients is that they are treated not as adults but more like small children or, even worse, as mere cases. He will be on the look-out for people who are given the run around when they make a legitimate enquiry, or when they present themselves at the admitting or emergency departments. He will be alert to the image of the hospital which his employees hold and which they disseminate outside the institution. Having taken the time to see his institution through the myriad eyes of others, he will be in a sound position to improve its service and thus sharpen a true image of the hospital in the eyes of the community.

Relations with the Medical Staff

FROM all reports, one of the most difficult problems faced by the hospital administrator lies in his relationships with the medical staff. Doctor X is impossible to get along with and Doctor Y is always complaining — or so thinks the administrator. Why this should be so when both the physician and the administrator have the same ultimate goal is difficult to comprehend, yet nevertheless, it is true.

We feel that the basic cause of the administrator-physician differences is a deeply instinctive one and difficult to solve. The administrator, charged with the responsibility for a large plant and many patients must, in the large hospital, deal with these patients in the mass; while the physician, by virtue of his training, personal inclination and professional responsibility, must deal with each patient as an individual. The administrator must think of the greatest good for the greatest number—this is his creed; the physician is concerned with only one patient at one time (other than in cases of disaster). He is concerned as to whether or not Mrs. Jones, lying in bed with a broken hip, gets adequate nursing care and is determined that "by golly she's going to get it".

This, then is the problem. Although the administrator and the physician have the same end in view their means to this end are so divergent as to seem incompatible. But are they really? We do not think so. It should be possible to bring these widely divergent viewpoints closer together by mutual understanding and tolerance. If the administrator can modify some of the physician's more radical demands and if the physician can liberalize the administrator's conservative stand, it should not be difficult for them to achieve in harmony what they are trying to arrive at independently.

While this calls for a forebearance and discipline on the part of both the administrator and the physician, we feel that the resulting benefits to patients should make the effort well worthwhile. — *G. Mc*

Nightingale Anniversaries

FIFTY years ago, on August 13, 1910, Florence Nightingale died in London at the age of ninety. A hundred years ago her creation, the Nightingale Training School for Nurses, opened on July 9, 1860, at St. Thomas' Hospital in London. Her name will always be linked with 19th century advances in the care of the sick and the promotion of health and especially with the transformation she achieved in the status and training of nurses.

The story of her work with and for the sick and wounded in the British army in the Crimea and Scutari is well-known. Thanks to her efforts, a Royal Commission was appointed in 1856 to inquire into the health of the army. She then disappeared into private life as a semi-invalid but continued her work behind the scenes. And the cause of nursing was foremost in her thoughts. When the school named after her was opened in association with St. Thomas' Hospital, the first students were chosen under her personal supervision. Moreover the school was financed by the Nightingale Fund for Training Nurses into which Miss Nightingale had converted the money raised by a grateful public as a personal gift to her for her services to the British Army. Her school is still flourishing and famous. See page 50.

This year Miss Nightingale is honoured again with the establishment, by the Ontario Hospital Services Commission, of a new school of nursing which is to bear her name. Even as we go to press students in the first class are being chosen from the many applicants, the class being restricted to approximately 30. Classes will be held in temporary quarters while a new school building is under construction. Academic instruction will run concurrently with practical hospital experience in one or more Toronto hospitals. The Nightingale School is new and its program is new—a concentrated two-year course leading to registration. Its progress will be watched with interest. — *J.F*

"Now or Never"

ACCORDING to an article in the *Bulletin* of the Canadian Tuberculosis Association, Dr. Rene Dubos, eminent microbiologist of the Rockefeller Foundation, claims that now is the time to eradicate tuberculosis—it is now or never. Here are a few points made by the writer.

The reason given by Dr. Dubos for urging greater pressure at this time is that in his opinion the curve of the tuberculosis epidemic has reached the bottom . . . and any delay in making full use of scientific ad-

(concluded on page 98)

at the Brantford General—

after a long-term building program

Memorial stained glass window in chapel donated by Dr. and Mrs. N. W. Bragg. Dr. Bragg is chairman of the board of governors.

Arthur H. Peckham Jr.,
Toronto, Ont.

THE story of the present Brantford General Hospital goes back many years—through a period of development such as many other hospitals are now facing or about to face. This is a time which demands courage, conviction, and the far seeing perspective of men and women who know where they are going. For their efforts in achieving this excellent hospital the board of governors, the administrator, the medical staff, department heads, the architect, and others, deserve the enduring gratitude of the citizens of Brantford.

Why is this so true? Back in the forties, the Brantford General Hospital felt acute growing pains. The big problem was how to enlarge and consolidate the existing hospital complex. Then it consisted of the relatively new Queen Elizabeth Pavilion to the west, the older Wings Pavilion to the east, plus a 180-foot connecting passage between the two which also connected with the original Stratford building to the south. The latter housed, in severely limited space, the surgical suite, maternity department, the central sterile supply and other major services. To add to this obvious planning dilemma, the laundry, boiler plant and dietary department occupied a central key position opposite the Stratford building to the north — unfortunately blighting the adjacent main hospital entrance in the Queen Elizabeth Pavilion. Care of the chronically ill was undertaken in the Terrace Building, a converted nurses' residence to the east of the main hospital wings. And to the south, a steep 40-foot drop in grade left little property upon which to expand in that direction — not to mention the fact that to the north most of the land was in use. In fact, the site then accommodated seven wings leaving little area for expansion on its level portion. Of course, the hospital needed more beds — expansion from 277 active treatment beds to approximately 600 beds.

The author is a partner of the hospital consulting firm, Agnew, Peckham and Associates, Toronto.

In truth, many years were energetically absorbed before a solution was found which would achieve the main objectives. These included: expanding all hospital services and facilities; consolidating the more or less scattered sections of the hospital; removing the boiler plant and service building from the front lawn; and creating, above all, an over-all master plan which would offer a logical pattern of growth for the years to come — without ever again having to face the problems then existing. This tremendous task had to be accomplished without undue disturbance to the normal functioning and operation of the hospital.

In 1945 a scheme was evolved which envisioned a multiple-stage building program which indeed was to place many hardships on the hospital staff in order to reach the final goal. But it was considered well worth the sacrifices involved. There would be, and were, many months of disturbance to one department or another.

1st step

The solution first involved the relocation of the laundry and boiler plant on the south-east corner of

Hospitality and gift shop.

Front view of the hospital showing upper level of tri-level parking lot.

the hospital site. Then Wing "A" was constructed. It is an "L" shaped wing to the north and west attached to the north end of the Queen Elizabeth Pavilion. In this new wing are housed such major services as the surgical suite, laboratories, x-ray department, delivery suite, new dietary department, emergency suite, a new elevator core and patient areas. The construction of this wing forced the closing of the main hospital entrance and the temporary relocation of the administration.

2nd step

Because of the limited building area, Wing "A" became a unique combination of a single and double-corridor plan. Both were used to full advantage in that such services as the surgical suite, laboratories and so on, were efficiently planned in the double-corridor leg of the "L" and nursing units in the single-corridor wing. The dietary department required a large amount of space and, therefore, a one-storey extension to the south was necessary on the lower level.

3rd step

Once this wing was constructed and in operation, step three was immediately undertaken — perhaps the most difficult of all. The master plan proposed the creation of a single-corridor nursing unit wing between the Queen Elizabeth and Wings Pavilions, just north of the original connecting passage, thus physically integrating all hospital wings and creating a unified whole. The eight-storey structure, during the planning stage, was called Wing "B". Primarily, it is a nursing unit wing above the first floor. On the lower level a wide base was planned for administration, including a new main entrance, a spacious visitors' waiting room, and a hospitality shop, plus other allied administrative areas. On the ground level, space was assigned to a new central sterilizing and supply department, physical medicine, pharmacy, personnel health unit and other departments, all of these were located in this wing in order to establish good interdepartmental relationships between clinical areas, nursing service and domestic service, all in turn, related through a new vertical circulation core.

With the opening of Wing "B", now called the John H. Stratford Pavilion, in August 1959, the final step of the original master plan was completed—after more than ten years of waiting and planning, of disruption and construction. Pages could be written outlining more intimately the step by step advances, the unforeseen problems and delays—the usual course of all planning and construction programs.

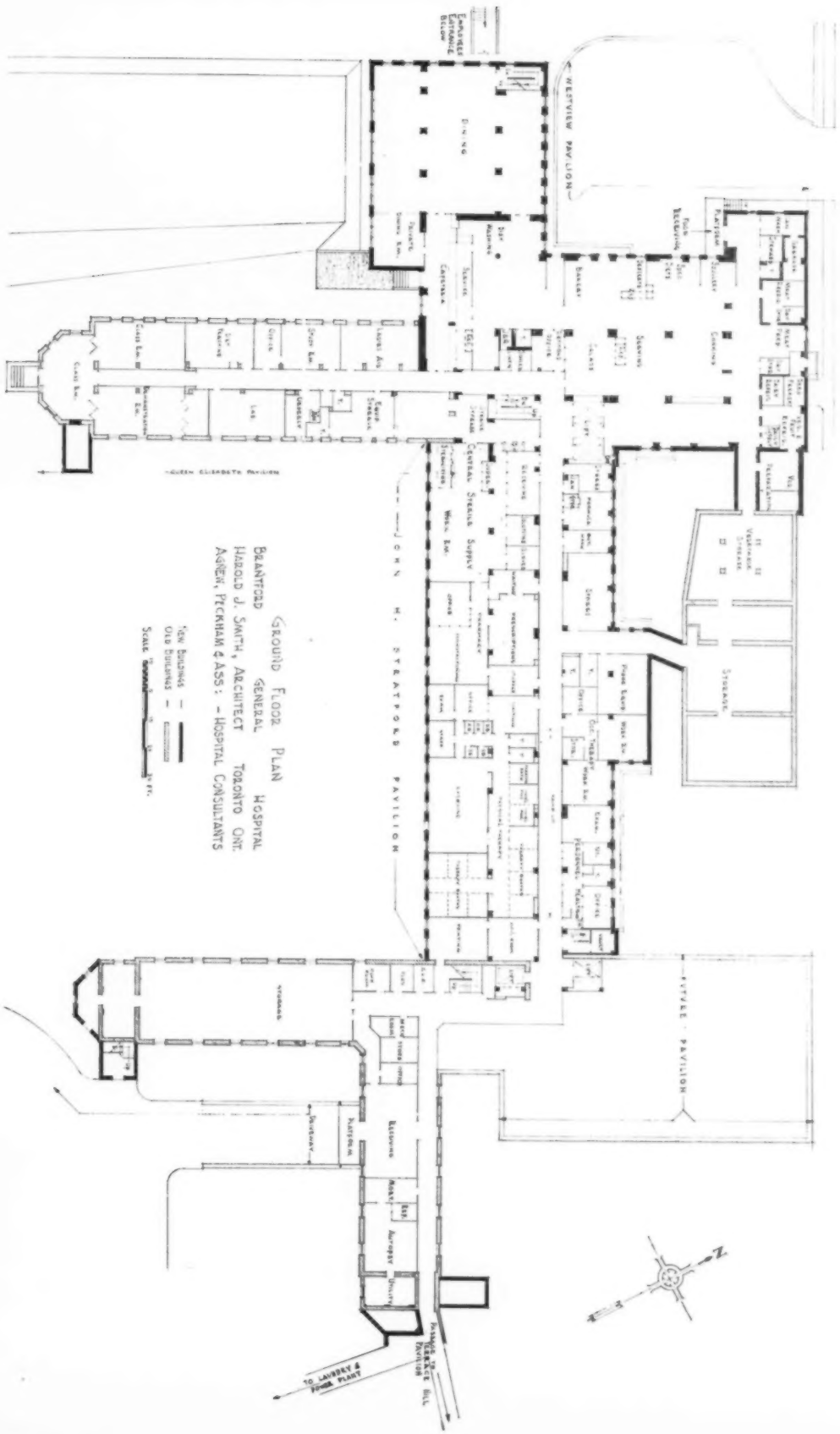
And the story is not yet over in Brantford, for renovation of the Wings Pavilion is now under way and also plans for a new nurses' residence and school—to accommodate 250 students. And the door is still open, for the master plan was designed to permit further enlargement of the hospital. So a hospital story never ends.

Internal Design

Now a word about the internal planning and the design features which are worthy of comment. The marriage of the double-corridor and single-corridor plan is a good example. Both are used to advantage in hospitals these days; but in Brantford they have been used to solve specific problems imposed by limitations of the site and existing structures, and the desired internal work flow within departments.

For instance, the double-corridor surgical suite resulted in a well-planned unit from the point of view of patient and staff circulation, supervisory control and the centralization of work areas. The distances of travel involved to reach the work core from any of the operating theatres is minimal and therefore, time saving. These same advantages are found in the layout of the laboratories, and in relating the emergency and cystoscopic suites to the x-ray department. The central sterilizing and supply department which occupies space on the lower level of Wing "B" has the advantage of a large rectangular layout with the result that the work flow is consistent with the most progressive thinking in the field and achieves real efficiency.

The use of a wide base on the lower two floors of this wing pro-


GROUND FLOOR PLAN
BRANTFORD GENERAL HOSPITAL
HAROLD J. SMITH, ARCHITECT TORONTO ONT.
ASHER, PECKHAM & ASS'T. - HOSPITAL CONSULTANTS
JOHN M. STRATFORD PAVILION
WESTVIEW PAVILION
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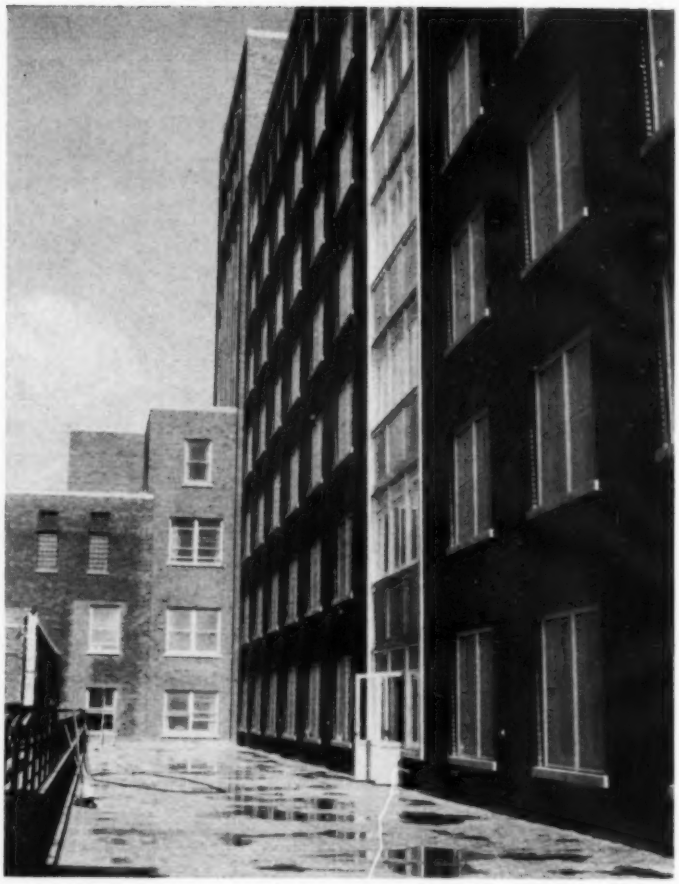
DINING
KITCHEN
CENTRAL STERILE SUPPLY
STORAGE
LAB
LAUNDRY
MORGUE
AUTOPSY
TO LAUNDRY & POWER PLANT
PASSAGE TO EMERGENCY DEPARTMENT

vided the large floor areas required by the various sections of administration, including the necessary offices, a board room, chapel and an adequate medical records area.

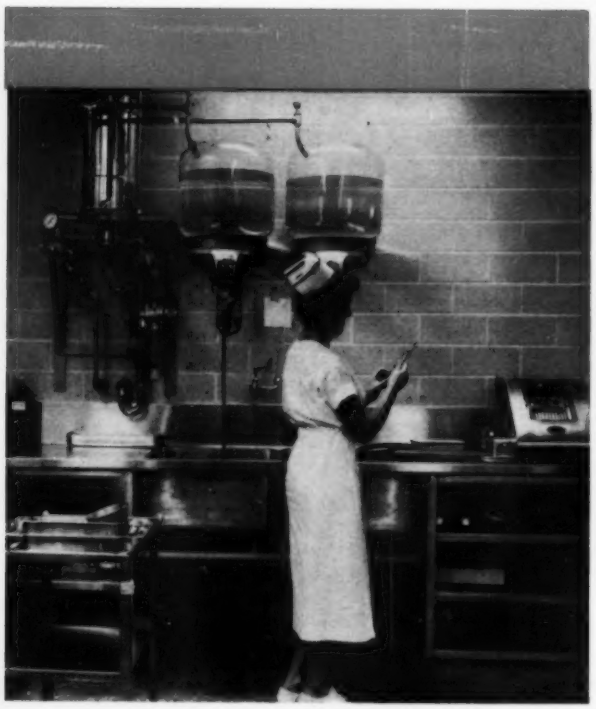
The nursing units in the new John H. Stratford Pavilion were given special attention in order to avoid pitfalls of earlier designs. The clean utility and medication areas which justly adjoin the nurses' stations, have been designed in a free flowing manner to avoid cross circulation and personnel crowding. An up-patient room has been placed opposite each nurses' station for reasons of supervision, for providing light in the general area of the station and since the latter is often a beehive of activity and an unavoidable source of noise, patient areas have been avoided in the immediate vicinity. Naturally, an automatic audio-visual nurse-patient call system permits this liberty in design in contrast with other layouts which plan patient rooms around the nurses' station and locate the solarium at one end of the nursing unit or the other.

Children's Floor

Perhaps the most appealing nursing unit is the one for children. The Board of Governors did not aim to save money here. Children should be given every consideration,

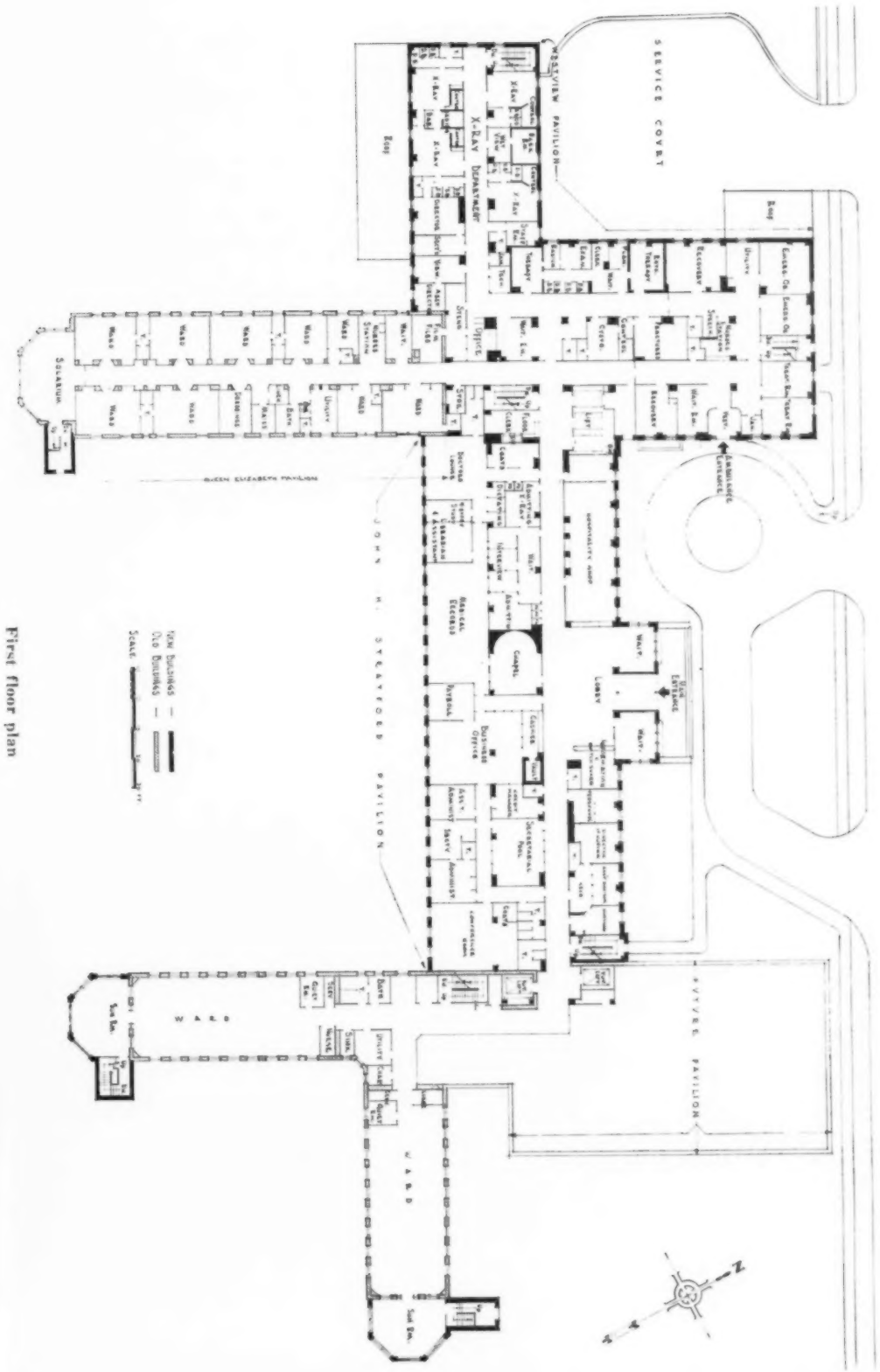


Patient's sun deck which is 175 feet long.



View in the central supply division showing sterile water apparatus.

Four-bed ward. Note ceiling mounted draw curtain with transparent upper section.



First floor plan

especially in a hospital—foreign ground to them. Each room is slightly larger than normal, permitting a central play area and the possibility of serving meals at a central table. One or two rooms have been designed to allow a mother to stay with her child overnight. This is comforting. For the younger boys and girls, the usual clothes lockers have been omitted. Instead colourful chests of drawers are used to store clothing—a three year old hardly needs a six foot wardrobe. The atmosphere in this unit should certainly allay any fears the sick child might have. The nursing unit is complemented by a cheerful playroom opposite the nurses' station which cannot escape supervision. And finally, there are no fixed bassinet cubicles in this unit but rather two types of accommodation — rooms for young people similar in layout to normal adult rooms and rooms for younger children who may require a crib or bassinet. A storage room for these latter will permit rapid changeover of rooms upon demand.

The dietary department is described on page 45. Here the delightful atmosphere invites one thing—gaining weight. And speaking of atmosphere one cannot overlook the colourful interiors throughout. A giant step has been taken towards creating cheerful, restful and inviting areas in all departments.

Again it is worthy of repetition to state that the Brantford General Hospital has overcome very difficult problems and achieved outstanding results, because of the men and women who have had the vision to see the results before they become a reality. ■

at Brantford . . .

Extended services

THE new facilities thus far completed provide for the Brantford area many services which were either inadequate or unavailable in earlier years. There are the excellently equipped and staffed departments of radiology and pathology which, of course, most hospitals of this size do provide. The large and comfortable psychiatric department (see 4th floor plan and page 44) is a forward step and is filling a great need in southern Ontario.

Again there is a well-equipped department of physical medicine and rehabilitation, a division which has met with great favour by the

Brock H. Payne,
Administrator

Workmen's Compensation Board. In this connection, financial assistance has been provided by the local Rotary Club to enable the hospital to incorporate in its out-patient service a therapy pool for crippled children. The club holds its regular crippled children's clinic at the hospital where they receive treatment; and it is working with the hospital toward setting up a permanent Crippled Children's Centre there.

Intensive Care

To assist in maintaining a high standard of patient care, despite an increasing shortage of nurses, the Brantford General has set up a special medical-surgical intensive care unit for critically ill patients. Here these patients receive the highly specialized care they need and the work load in other nursing units is lightened. Among the facilities provided are over-bed surgical lights, piped-in oxygen, and suction apparatus. Emergency drugs, instruments, intravenous solutions, dry supplies, an x-ray viewing box, and equipment for use in cardiac and respiratory arrest are all ready for immediate use. The unit has its own nurses' station, linen closet, utility room, two bathrooms and a maid's closet.

Patients are admitted or tra-

The spacious and efficient medical record department.

Comfortably furnished doctors' lounge.

ferred to this unit upon the request of their attending physician, the patient's family, or sometimes the patient himself. Arrangements for this accommodation are made through the admitting department but if private duty nurses are to be engaged the patient is not admitted to this area.

A patient remains in this unit until the attending physician indicates that special care is no longer necessary and then is transferred, when possible, to the same floor where he or she had been admitted. The intensive care given in this area is one phase of progressive patient care which implies a grouping of patients according to their disabilities.

The hospital also has a long-term care unit and a completely organized isolation division and these help to round out a very comprehensive hospital service.

Special Features

In planning and furnishing this hospital everything possible has been done to provide for the comfort of patients, the convenience of physicians, and good working conditions for all employees.

Today there are over 300 electrically operated beds in the hospital and there will be more in due time. These push-button beds, which can be so readily lowered to a normal bed position, are a source of satisfaction to those patients who are able to walk about when they wish and to the nursing staff they provide a welcome saving in time and labour.

Another special feature is wall-mounted television with under-pillow receivers and bedside control. These units give much pleasure to many patients and the individual receivers permit any one patient to watch and listen without subjecting others to inconvenience or possible irritation.

For the sake of quietness, among other reasons, it is proposed to provide electrically operated trucks for transporting both patients and materials.

A beauty salon has met with great favour among women patients and the attentions received there do much to build up morale in the person who is ill. There is also a barber shop for men.

A smart cafeteria and a very pleasant dining room are innovations which delight the staff and may be used also by visitors (see page 45). Off the main rotunda of the hospital is a most attractive tea and gift shop which is the

On each floor there is a solarium for patients and visitors.

New pharmacy department pass-through for dispensing.

Glove processing in the central supply department.

special project of the Women's Hospital Auxiliary.

For employees, there is also a health unit where they may receive first aid and advice.

This hospital has set aside two comfortably furnished guest rooms for the use, in emergencies, of visitors from out of town. Here relatives of patients may be accommodated when it is necessary for them to wait many hours. This sometimes happens as the result of a highway accident and the comfort thus provided is very much appreciated.

An outstanding convenience to both staff and visitors is the large and well-designed parking lot which will accommodate some 300 cars. Angle parking on a three-level area provides this hospital with an excellent solution to an aggravating problem still suffered by many institutions.

Public Relations

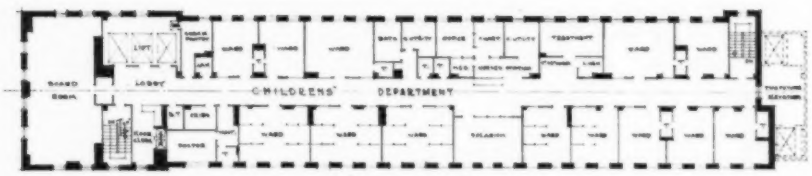
A public relations program has been followed at the Brantford General Hospital since the building program was launched some seven years ago. It is an organized effort on the part of everyone connected with the hospital to "sell" the institution at every opportunity. This is carried out through ladies' organizations, service clubs, press, radio and television outlets. Through a program organized by the administrator, the people of Brantford and Brant county were alerted to their responsibility to support their community hospital. When a united appeal was launched the citizens responded generously and loyally, helping to make the new hospital the excellent one it is today. But the public relations effort is a continuing one and the human interest stories which appear in the local press keep the hospital in the limelight. Speaking engagements on the part of board and staff members have also been an effective medium for publicity. Brantford General Hospital turns to its community for the support which is constantly required in order to maintain a high standard of hospital service and it enjoys the confidence of the people whom it has been constructed to serve. ■

Psychiatry

G. H. Lugsdin, B.A., M.D.,

IN JUNE, 1958, a 24-bed psychiatric unit was opened in the new West View Wing. As this proved inadequate to meet the needs of the community, an adjacent medical ward was taken over, which increased the psychiatric ward to a total of 34 beds. There are six single rooms (including two seclusion rooms), one four-bed room, the remainder being two-bed rooms.

The author is engaged in the private practice of psychiatry and is employed by the hospital on a part-time basis for administration of the psychiatric ward. Other staff personnel include eight grad-



Eighth floor plan

Fourth floor plan

ur e nurses, seven nursing assistar s, five male attendants, three cl ning women and one secretary. Th occupational therapy departm t is under the direction of the la es' auxiliary pending appointm t of a staff occupational therapi . The services of a social worker ar psychologist have not yet been ob ined.

he majority of patients are re rred by their family physician, as we wish the family physician to ave continued contact with his pa ents. In emergency situations, pa ents are accepted from other so ces such as community welfare or, nizations and the court. The bu of admissions come from Br ntford and the surrounding ar , but there are no boundaries se and a few come from distant ce res. Any patient is admitted wh is deemed likely to benefit by short-term psychiatric treatme t in hospital.

Specific treatment methods inclu e electro-convulsive therapy, sul oma insulin therapy, narcothe apy and narcoanalysis, the bro d spectrum of tranquilizers and anti-depressant medications, in addition to psychotherapy, occupatio al therapy, recreational therapy and nursing care.

In 1959, 302 patients were admitted, the median length of stay being 21 days, less than five per cent were committed to an Ontario Hospital, the unit being geared to active and intense treatment. In the future, a separate out-patients' department is planned. At present, discharged patients are given follow-up care by the psychiatrist in his office in the hospital, and a limited number of out-patients are treated without admission to the hospital. ■

Formulae room.

Dietary Department

—*now centralized*

Doreen N. Johnson, R.P.Dt.

THE prime purpose of the dietary department in any hospital is to provide, in an efficient way, as desirable and nutritious meals as possible for both patients and staff, within a controlled budget.

With this purpose in mind, the new dietary department of the Brantford General Hospital was designed by qualified and experienced dietitians.

The move to our modern department, in June of 1957, represented a great change both in equipment and type of service. A brief description of the former department will help to illustrate how much progress was made when the new dietary department was added to our hospital.

Before

The earlier department, which was completely decentralized, consisted of a kitchen and dining room comprising 2,008 square feet —the kitchen had 1,058 square feet. Dining room (seating capacity, 96) had 950 square feet. The kitchen consisted of two sections —the cook's area, baker's area, butcher's area and pot washing area in one section; the special diet kitchen and dish washing (diet trays only) in the other. The main kitchen was equipped with a double bank of coal stoves, double deck bake oven, mixer, two stock pots, electric grill, and fryer and three small work tables. There was one gas-operated walk-in refrigerator in which all meat, dairy products, fruits and vegetables were stored. With this limited area for preparation and storage and out-dated equipment, it was impossible to offer a selective menu to the patients, although a limited selection was possible for the staff. Service to the staff was from a small steam table unit adjacent to the dining room. All dish-washing was done by hand in the ward kitchens for the patients and in a small area off the dining room for the staff. From this department a daily average of 1,102 meals were served.

The opportunity to plan a new department was a great challenge and the trend to centralized dietary service was followed. In contrast with the old, the new department, located on the ground floor of the Westview Pavilion, is spacious and well equipped with a total floor area of approximately 12,721 square feet, distributed as follows:

1. Main kitchen area—5,957 sq. ft.
2. Storage area —1,389 sq. ft.
3. Dish room and offices —1,196 sq. ft.
4. Cafeteria — 873 sq. ft.
5. Dining room —3,306 sq. ft.

To ensure ease of cleaning, equipment and work units are constructed of stainless steel, wherever possible.

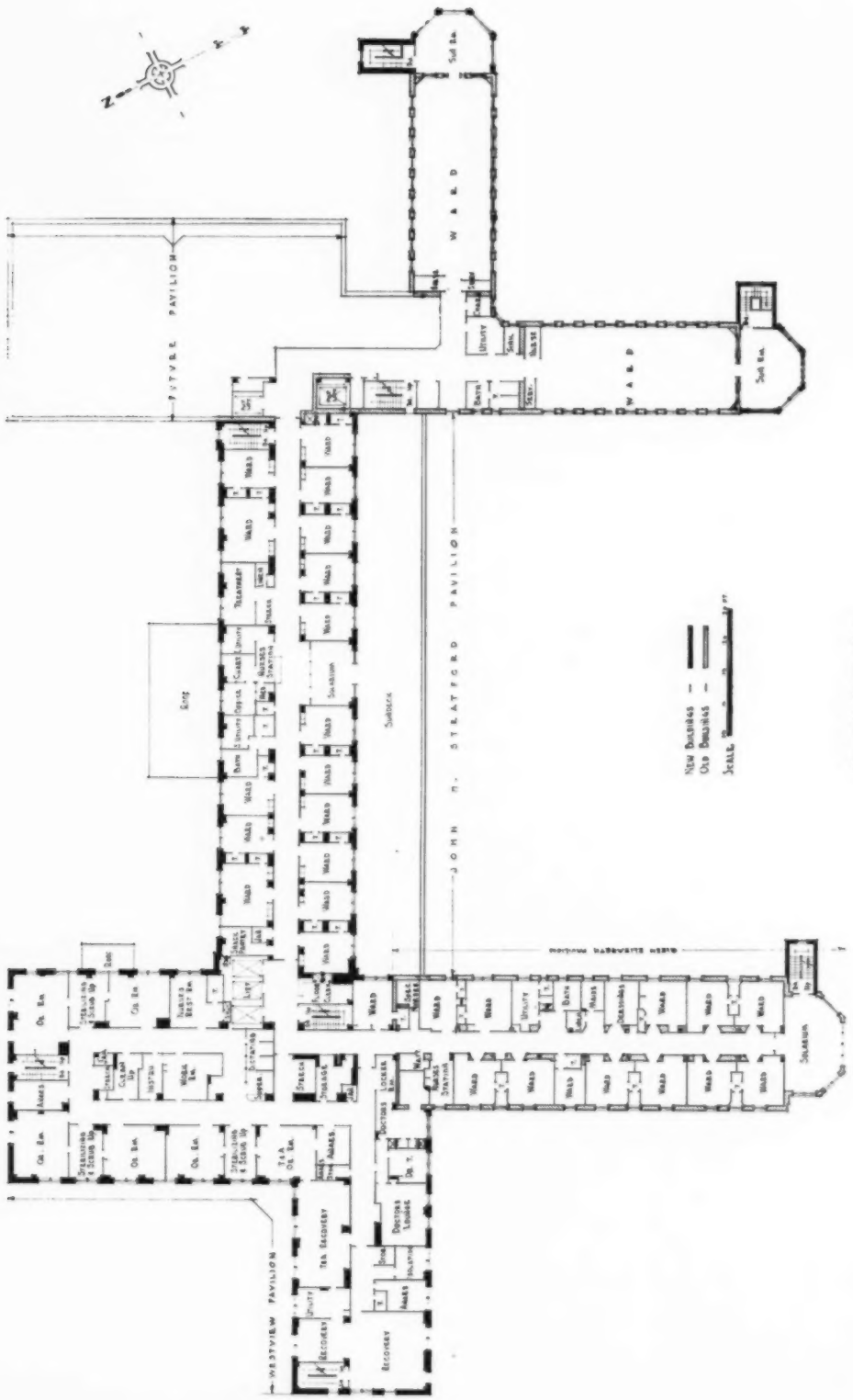
In the planning, careful consideration was given to providing a smooth flow of traffic from receiving, through storage and preparation to service, with a minimum of cross traffic involved. A description of each area will help to show how this has been accomplished.

Main Kitchen Area

This area consists of the following six divisions:

(a) *Receiving and Storage.* Adjacent to the receiving entrance is a long corridor along one side of which are located the garbage can wash and refrigerated garbage storage; clerical office, meat refrigerator equipped with overhead tracks from the receiving dock; butcher's preparation area; day

The author is director of dietetics at the Brantford General Hospital, Brantford, Ont.



Second floor plan
Architect: Harold J. Smith, Toronto

storage room; dairy refrigerator; fresh fruit and vegetable refrigerator with deep freeze section; main kitchen refrigerator; vegetable preparation room and salad preparation room. This corridor leads into a large storage area (2 above) for canned goods and paper supplies ordered from central stores three times weekly.

(b) *Cook's Area.* The main cooking area is in the form of an island with the electrical equipment barred against the steam equipment under a single stainless steel canopy. Stainless steel work tables are located at either side of the island. This area is located opposite the butcher's preparation area and the pot washing area is located at the end of the cook's area. All hot food, including that for special diets is prepared here and distributed to the conveyor service, special diet area and cafeteria.

(c) *Conveyor Service.* The conveyor service for the patients is located parallel to the cook's area. The conveyor belt is 32 ft. long with the hot food and cold food sections stationary, and all other equipment mobile, *e.g.*, cup and saucer lowerators, plate lowerators, tray lowerators, et cetera. All regular and special diet trays with the exception of sodium-restricted and diabetic trays are served here. A dry heat system (heated pellets below plates) is used to ensure hot food for the patients. Insulated individual soup and beverage thermoses are now being introduced—which will make each tray complete when it leaves the dietary department.

(d) *Special Diets.* This area is located opposite the starting end of the conveyor. Trays for sodium-restricted and diabetic patients are served and checked here and put on the conveyor belt for the proper ward.

(e) *Baker's Area.* This is located adjacent to the special diet area and is well equipped with triple deck bake oven, tilt kettle, proofer, mixer, hot plate, refrigerators and work tables. All baked goods with the exception of bread are produced here.

(f) *Truck Parking.* This area is separated from the cook's area by a storage cupboard and is in line with the conveyor service so that trucks may be loaded and taken directly into the service elevator.

Dish Washing

The dish washing room is equipped with a flyte type dish washer and is located behind the cafeteria and adjacent to the dining room. All trays from the dining room are transported on a conveyor belt directly into the dish room. Patients' trays are also stripped in this area and the tray trucks washed before they are returned to the truck parking area.

The dietitian's office is conveniently located and windows on two sides afford a view of the dish room and main kitchen area.

The serving area of the hospitality shop.

Cafeteria

The cafeteria service counter, which is 42 feet long and of stainless steel construction, is divided into a dessert section, hot food section, salad table and beverage area. There is ample space to offer a wide variety of food to the staff. The cafeteria and dining room are open almost continuously from 7.00 a.m. to 4.00 a.m. to provide meals and nourishments during all shifts.

The dining room, with a seating capacity of 256, has windows on three sides and is pleasantly decorated to provide a relaxing atmosphere for the staff. Quiet music provided on a hi fi record player adds to the atmosphere.

With this new and modern dietary department we are now able to provide for our patients and staff a much wider variety of foods. All patients with the exception of those on gastric no. 1 and no. 2 diets, receive selective menus daily. These menus rotate on a five week cycle—all fresh fruits and vegetables being introduced in season. The greater variety in preparation involved with a service of this kind is handled with ease in the well equipped kitchen. The change to the centralized service has resulted in improved patient satisfaction and reduction in waste through the use of selective menus and portion control. A wider variety of foods is also much appreciated by the staff. Under the supervision of dietitians, trained personnel prepare and serve 1,800 to 2,500 meals per day.

Such a drastic change in food service as we have carried out in our hospital could not have been accomplished without the co-operation of the nursing personnel. To encourage continued co-operation and to promote inter-departmental relations, all graduate nurses and nursing assistants joining the staff, spend a ½ day in the dietary department to become orientated to the services, functions and routines of the department.

Since, through a well-planned and well-organized dietary department, we are now able to provide greater satisfaction to both patients and staff, we thereby promote better public relations within the community. ■

Food Service

sponsored by the

Canadian Dietetic Association

idealistic or realistic?

INTEGRATED HOSPITAL PLANS

L. F. Detwiller, M.A., M.H.A.,
Victoria, B.C.

IT WAS at the stage (in hospital development) where public bodies became involved that the first positive action was taken on the part of the community to determine the hospital or health facilities required. This usually involved a survey of some kind, with subsequent recommendations, which were considered by the council or body appropriating funds. Sometimes these surveys were conducted by independent health organizations or sometimes by the staffs of the communities themselves, and were made to ensure that there was need for hospital facilities and that any future development would not result in duplication or over building. Surveys of this type have become one of the accepted means of determining the most efficient way of expending funds, and are often the result of financial participation by interested groups.

With the introduction of federal health grants in 1948, we find the federal government making moneys available for health surveys in the various provinces, as such surveys were required before certain other funds would be available.

With the introduction of provincial hospital plans, especially when these plans provide almost all of the financial support for the operation of hospitals, it is not surprising to find that the provincial authorities wish to know why funds are required and what is done with them. This usually requires a survey of some type to determine the extent of the problem or demand, and make recommendations as to its solution.

If the central agency providing financial support (be it federal or provincial governments, or a local community) were to accept all of the representations for construction received from independent hospital boards, and recommend grants as requested, there very likely would be a duplication of facilities and over construction in the area, since each individual hospital board is generally concerned only with its own program and not that of others. This being the case, the central authority then must employ some instrument of measurement not only to determine the present and future hospital needs of the area but also evaluate the present facilities and the care which is provided so that it may be weighed against the requirement and plans for the future.

In this regard, it is interesting to note that, in the majority of the provinces, now members of the federal-provincial hospital plan, most of the hospitals are operated by independent hospital societies, sisterhoods or churches, and are not owned or operated by the provincial governments. This is a rather unique development in the hospital field when one considers that the provincial governments raise the funds in various ways to meet the hospital bill of their people and then, in essence, pay these funds to the independent hospitals (on behalf of the people) and ask them to provide the hospital service which the government has undertaken to underwrite for the public. In British Columbia, the pattern which has developed and which is supported by all concerned is to have hospitals owned and operated at the local level rather than by the provincial government. As each hospital board and medical staff has certain standards and goals which it would like to achieve, and since these programs will have a direct bearing on the over-all cost of the provincial scheme, the central authority must, *in some way, co-ordinate and integrate these aims and objectives with its financial resources and develop a plan by which as many as possible of the aims and objectives of the individual hospital boards and medical staffs can be achieved*, and yet keep the cost within the ability and willingness of the people to pay. This inevitably must result in compromises, since it is doubtful if the hospital field will receive a large enough share of any provincial economy to meet the plans and programs of all the hospital boards and medical staffs within its jurisdiction. It is quite possible that two or more hospitals may plan services which duplicate each other and serve the same population, simply because they are not aware of the plans of other hospitals.

However, each province is now charged with developing a hospital plan and has a responsibility to make certain that the plan is efficient and properly operated. The types and volumes of hospital care required should be decided upon, and this will involve surveys. If as a result of a particular survey, it is determined that there are sufficient facilities to provide a specific service in a given area, further requests to add this particular service would not receive provincial support. To add more would mean less efficient operation of those existing. It is at this point that problems begin to develop between the central authority, the hospital, and the professions involved.

While the refusal to support an extension of services may be the logical approach for the central authority, such a decision is likely to be a great disappointment to the hospital and medical staff of the hospital concerned. The question then arises as to whether the patients and medical staff and others connected with the hospital planning the development of the new service should be denied this service in their own hospital and be required to go to another institution in another area. It could well be that the hospital which has just applied for the development of the

From an address presented at 42nd annual convention, British Columbia Hospitals' Association, October, 1959. The author is Assistant Deputy Minister of Hospital Insurance, B.C. Mr. Detwiller prefaced his address with a brief review of early hospital development and medical advances.

specialty and has been refused is, in reality, better qualified physically and professionally to provide this service than the one where it is already located.

If both hospitals were operated in a purely local environment and were not receiving funds from a central authority which embraced these communities, it might well be that the hospital desiring to establish the new service would proceed with its plans and possibly bring about an over-development of this specialty in the particular area. How far this over-development would go would depend upon the boards of trustees and medical staffs of the hospitals concerned. It could reach—and in a good many communities on this continent has reached—serious proportions before the forces of competition and public opinion began to make themselves felt, ultimately bringing about a reduction and co-ordination of facilities providing this service. However, in this process it could well be that, in the final analysis, the hospital which first introduced the service might not be the one to retain it. This would depend on the medical staff, the ultimate aims and objectives of the hospital, its clientele, and community support. The compromise in solving this type of problem in the hospital and medical fields is something which we are all searching for at the present time and should be studied carefully by hospital and medical staffs at the local level.

Experience, here and elsewhere, has shown how difficult it is to integrate and co-ordinate the basic concepts and principles of some of the groups involved in the medical and hospital care fields. Examples can be found where these differences have defeated some of the proposed over-all hospital programs because of the interests of individual hospital boards and medical staffs. Councils have been established in some of the larger metropolitan centres to try to achieve this integration, with varying degrees of success.

An example of this type of planning is to be found in the Greater Detroit area. It has a Metropolitan Detroit Building Fund into which is periodically poured millions of dollars for hospital construction programs. It also has a Greater Detroit Area Hospital Council, which deals with hospital policies and programs. It makes recommendations to such prepaying organizations as the Blue Cross as to whether or not a hospital should be participating in a particular prepayment plan. It is interesting to note that it has public representation and, in fact, the president of the Council is from one of the large automobile companies. Recently, the Greater Detroit Area Hospital Council completed a survey of the general hospital needs of the Detroit area. Recommendations will be made to the Metropolitan Detroit Building Fund for future construction and programs, based on this survey. Since the Building Fund and the Hospital Council directors are almost identical, it is reasonable to expect that the Fund will not allocate any moneys to organizations which have not been included in the survey of the Hospital Council.

However, in addition to these two bodies, some 26 communities in the neighbourhood of Detroit have grouped themselves into what is called "The People's Community Hospital Authority." This latter body has taxation powers, floats bond issues, and currently has three hospitals in operation, and is now in the process of constructing a fourth.

It seems obvious that the Greater Detroit area has found it desirable and necessary to adopt an integrated hospital program, which is following a pattern of development not unlike that which appears to be emerging in several other areas such as Minneapolis, parts of California, and Eastern Canada.

In the Detroit plan, a financial mechanism has been developed which will enable the support and the co-ordinating of the construction projects recommended for the area. This will ensure that a very important section of the plan does not go forward simply because the individual hospital is not in a financial position to accept the part of the over-all plan which has been assigned to it. This is one of the very difficult problems which must be solved in connection with any integrated plan; namely, that of financial support.

One field which is sometimes not given sufficient thought and study is the type of medicine practised in the area. It is well known that this has the greatest effect on the hospital's cost of operation. There should be close co-operation between the medical profession and the hospital planners in deciding what types and volumes of services are to be included in the various hospitals embraced by the plan. The pattern of referral of patients to hospitals in which specialties have been developed is very important and concerns not only the area under survey or review, but also the total area served by the hospital group. The volume of referrals from outside can have a considerable bearing on the bed requirements in the plan under consideration.

Over-Use

Several other factors will have an effect on bed requirements. What type of prepayment coverage is provided for health services in the area; what facilities are available to which the patient may be discharged when he no longer requires the special services provided in the hospital. If an over-all plan for acute hospital care is under consideration, there are many questions which must be answered. For example: is the acute general hospital going to be used solely for the medical treatment of the acute stage of diseases, with no other consideration being taken into account; or are other factors, such as the home conditions, and availability of services elsewhere going to affect admission and discharge? There have been allegations by many that hospital facilities, both acute and chronic, and hospital insurance coverage plans have been *over-used* and *abused* by the public, with a resulting increase in the volume and cost of care in recent years.

The extent to which hospitals may be considered to be over-used or benefits abused depends on the individual's definition of the rôle and function of the hospital. If, at one extreme, the hospital is regarded as a life-saving institution, to be employed only when all other alternatives have failed, then we are likely to find that, in areas using this definition, there is a considerable amount of over-use. On the other hand, if the hospital is to be regarded as a community facility to be utilized whenever those services can help to provide better medical care than can be obtained outside (and this is meant to be interpreted in the broadest sense of the word, including non-medical factors) then the amount of over-use one is likely to discover under these criteria will be comparatively small.

This problem of abuse or over-use has been the subject of several extensive studies in the United States. It is interesting that they

(concluded on page 84)

View from a ward balcony.

at ST. THOMAS' HOSPITAL, London

100th Anniversary of the Nightingale School

FOR 100 years, whenever they wanted to know the time nurses at St. Thomas' Hospital, London, have looked across the River Thames towards the Houses of Parliament, for the Nightingale Training School at St. Thomas' Hospital and Big Ben are both the same age—100 years old.

In 1859, when Florence Nightingale was looking for a hospital in which to start her new training school for nurses, the old St. Thomas' Hospital at London Bridge was planning its new foundations across the Thames, opposite the House of Commons.

Miss Nightingale, with the £50,000 given to her by the nation for her work in the Crimea, selected St. Thomas' Hospital as a site (not as "the best conceivable but . . . the best possible"), and advertised for 15 probationers to start in the new training school.

It was the first nurse training school in the world and it represented the fruits of Florence Nightingale's experience throughout the hospitals of Europe and her nursing in the Crimean War. Now, 100 years later, 200 probationers start their four-years training each year, having been selected from as many as 2,000 applicants for vacancies in the Nightingale Training School.

Many women have come from overseas—from Sweden, Finland, Australia—to study in this famous training school and to take its traditions back to their homelands. Also a succession of British nurses have themselves gone abroad to establish training schools.

The aim of Miss Nightingale was to plan a systematic training scheme for nurses, with particular emphasis on the training of character, for she knew that she was training pioneers and leaders. Much of the original pattern of training has been retained.

The sisters still wear caps of starched Valencienne lace, with bows under their chins, and a uniform similar to that worn by the deaconnesses at Kaiserworth, where Miss Nightingale learned her bedside nursing in 1850. Nurses go through the stages of mauve and white stripes, blue and white stripes and then dark blue; striped belts, black belts, white belts and finally blue belts with a silver buckle.

The sisters' reports on the nurses in training are read and discussed by the matron with each nurse; case histories about different patients are still required to be written during training, as advocated 100 years ago, and the continual emphasis is on the responsibility of service. Against a rather Victorian atmosphere of training, the work of the nurses in the wards is in the vanguard of progress.

In this centenary year of the Nightingale Training School, there are again plans for rebuilding the hospital, which was bombed 15 times during the war. The new buildings will occupy the same site.

—From an article by P. D. Nuttall. Courtesy of the United Kingdom Information Service.

A staff nurse at St. Thomas' Hospital, London, instructs two probationers during elementary practical classes. The bust on the top of the cupboard is of Florence Nightingale.

for small hospitals

PUBLIC RELATIONS in the ADMITTING OFFICE

Sr. Mary Patrice, C.S.M.
Melville, Sask.

"THE admitting officer in a modern hospital is no longer merely a clerk who checks patients in and assigns them a room. To-day she is recognized as a person vital to the success of the hospital. In her position she can help the hospital carry out a sound public relations program in the community, since patients, relatives, visitors, physicians, and hospital personnel all have contact with her. The entire reaction of these persons to the hospital is measurably affected by the manner in which they are treated by the admitting officer".* So reads a paragraph in the introduction to the *Manual of Admitting Practices and Procedures.*

It is our purpose here to discuss public relations in the admitting office of the smaller hospital with reference to these specific groups.

To this end it is well to realize that there is a difference between the hospital in the smaller community and in the larger urban centre, and this is reflected in the admitting office particularly. Malm and Pannkoke, in an excellent article in *Hospitals* on the smaller hospital story[2], have brought this out very clearly when they explain why the smaller hospital is in its truest sense a community hospital. They point out that the larger an urban centre is the more it fails to be a community. It is rather a number of interest groups and, for most people in an urban centre, hospitals are rather impersonal institutions. Life in an urban centre is more or less anonymous and it is this anonymity that the larger hospital has to contend with, where patients are not known to members of the staff or to many of the other patients.

It is quite a different matter in the smaller community. Everyone knows the hospital and is proud of it. The whole community has stood together during the long months of planning, fund-raising and building. The small community hospital is human; it has a heart and the heart-beat of the community centres in the hospital, for smaller communities are neighbourly and the people are vitally and personally interested in things taken for granted in the larger institutions, such as births, deaths, recovery of patients and accidents because someone whom practically everyone knows is involved. Their people's happiest and saddest hours occur in the hospital and they rejoice or sorrow together.

In most small hospitals the responsibilities of the admitting officer are many and varied. Admitting patients is the primary function but she may also be responsible for the switchboard and information, as well as credits and collections of discharged patients with a few odd jobs thrown in. During the activities of a single day she may actually meet more people than any other person in the hospital — doctors, patients, relatives and friends of patients, visitors, salesmen, police officers, the press, hospital employees, telegraph and delivery messengers, clergymen, the undertaker, outpatients and discharged patients and prospective employees. The public relations of the community is carried on by these people and it is more effective than any formal program for it extends over the whole community and permeates into the hearts of its people. It follows then, that the worker in this department has a tremendous responsibility to interpret properly the policies, philosophies and procedures of the hospital to these people.

The manner in which she carries out her duties significantly influences the community's opinion of the hospital, for through kindness, consideration and courtesy to these diverse groups, friends are made — which is an essential of good public relations. It has been truly said that in the small hospital public relations is alive and is not so much a formal program as an indirect result.

The first services of the hospital to the patient are provided by the admitting officer who gives him his initial impression. This impression is generally lasting and a well trained clerk can help create a favourable one which will condition the patient's stay at the hospital and will be remembered after he has left the hospital. She must be particularly tolerant and kind for she is dealing with people who are physically ill, emotionally disturbed and not in a normal state of mind. It is relatively easy to deal pleasantly with one such person but difficult to maintain equanimity with an impatient, perturbed and apprehensive group of relatives. Understanding and compassion should be the keynote here.

Promptness and courtesy in dealing with patients is essential and if circumstances demand, as they will at times, that promptness be dispensed with, the patient should be told why—as well as the probable time that will elapse before service can be given.

In the smaller hospital it is extremely important that everything learned about the patient in the admitting office be held in strictest confidence. The admitting supervisor must be careful to impress this on her associate workers who are less likely to have learned it from past experience. She should be particularly alert to this aspect of confidentiality—for through the friendly spirit prevailing in the smaller community there is that tendency to be the first to pass on the choice bit of news.

Admitting personnel should be thoroughly familiar with government laws and regulations concerning the hospital and patients, as well as procedures of insurance companies, Blue Cross, Workmen's Compensation Boards, et cetera. They should be familiar with general policies of the hospital which relate to the admission of patients, and be conversant with the economic operation of the hospital so

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The author is medical records officer at the St. Peter's Hospital, Melville, Sask.

For references see page 88.

Hospital Financing and its Impact on Patient Care

Harvey Agnew, M.D.,
Toronto, Ont.

THE quality of patient care is not necessarily related to the financial status of the patient, for many hospitals are proud of the fact that their ward patients get the best in diagnosis and treatment—frequently better than that given to many private patients under their own doctors. But patient affluence does help, particularly when it comes to special nurses.

The financial status of the hospital itself is bound to have an effect on patient care. Or to put it negatively, patient care can be affected deleteriously by inadequate financing. This could be manifest in lack of equipment, inadequate professional and technical help, or the poor quality of the nursing.

Patient care could be affected by shortage of equipment in radiology or the laboratory, lack of incubators, or piped oxygen, or an electrocardiograph, lack of air conditioning, or improper heat distribution controls.

We can go back further and say that patient care is affected by what was provided when the building was erected. Limitation of budget often makes it impossible to provide what should be included. Nursing units may lack isolation rooms; children's wards may not be sufficiently flexible to separate suspect patients; obstetrical patients may be exposed to non-obstetrical patients on the same nursing unit. The construction may aid rather than prevent the spread of staphylococcus infection; patients may have to be delivered at times in labour rooms or in their own beds. The shortage of operating rooms may require open bone surgery to follow a pus appendectomy. The laundry may not be properly done. Food may be cold and unappetizing; sterilization may be untrustworthy; windows may be draughty and patients exposed to pneumonia—all because of inadequate capital expenditure.

There is no question, other factors being equal, that the hospital which has an adequate and modern plant should be able to provide better patient care. To achieve such a plant requires adequate financing. The development of federal and provincial construction grants has done much to assist in providing these physical features.

Newfoundland Observations

We must not, however, overlook the fact that the provision of all of the facilities and equipment available in the world would not necessarily mean ideal care, nor, conversely, its lack mean poor care.

This was strongly impressed upon me several years ago while making a survey of the hospital facilities in Newfoundland and Labrador. Most of the hospitals are in small fishing villages, or "outports", scattered in bays around the coast. The average size is about 20 beds, with one doctor, usually two registered nurses and a few local girls who are nursing assistants or aides and who, in many of these places, have not been able to go beyond grade X.

With such a staff the one doctor is required to do a wide variety of major surgery which cannot wait to go out by boat or plane. The nurses give the anaesthetic and act as first assistant. If a confinement is on, also, one of the nursing assistants takes over the retractors. The doctor may be up the coast on one of his medical visits and a storm may prevent his return; the nurses carry on. At the time of the survey a number of the hospitals had to generate their own electricity and some could only sterilize by boiling. Their equipment was limited to only what was really essential.

Despite these handicaps, the results obtained by these doctors and nurses were simply amazing. Patients made rapid recovery after operations for ruptured gall-bladders, gastric perforation, hysterectomies and other major operations. The glorious history of these outport hospitals has given us an outstanding illustration of the fact that good medical care does not necessarily require elaborate and costly facilities. We cannot judge care entirely by the cost.

Law of Diminishing Returns

In deciding how much should be invested in specialized equipment or in highly trained personnel, we must keep in mind the law of diminishing returns.

To illustrate, at the low end of the scale patients in a poorly staffed and equipped hospital would definitely benefit by the development of a better x-ray plant, a physical therapy department, a resuscitator or a blanket sterilizer, or by the appointment of a pathologist or a topflight operating room supervisor. All of us would agree that a moderate investment in staff and equipment should definitely result in a better quality of care and we might feel justified in saying that this or that life had been saved thereby.

On the other hand, take a hospital which has excellent equipment, a qualified pathologist and radiologist, good and ample nursing, skilled technicians, et cetera, the same further investment in staff or equipment should help some patients, of course, but the results would not be nearly so spectacular, and the over-all picture for the year would be but slightly changed.

The law of diminishing returns can be just as applicable in the hospital field as elsewhere.

Economies Which Could Jeopardize Patient Care

A decision comes up continually in hospital financing which may appear in varied clothing but which is basically the fundamental question: How far can we go in effecting economies without jeopardizing patient care?

Hospital operation has wo

Dr. Agnew is Professor of Hospital Administration at the University of Toronto and partner in the hospital consulting firm of Agnew, Peckham and Associates, Toronto. From a paper presented at the accounting section of the Ontario Hospital Association Convention, October, 1959.

primary objectives—good patient care and good business management. How can these be integrated and where do we draw the line? This is where the Finance Committee has a major responsibility. Usually selected because they are outstanding businessmen, they must put on another coat and recall that now they must evaluate costs from an angle other than production costs and sales.

A service cannot be discontinued because it does not pay; for example, the out-patient department, or cardiac surgery. A highly expensive piece of clinical equipment may be justified if only used once in six months, that is, if its use can save a life, or even materially increase the chances of recovery for a patient. On the other hand, an expensive piece of automatic equipment for the laundry could only be justified if it results in payroll or other savings.

An adequate number of qualified staff is essential. Today, with a shorter work-week and a more rapid turnover of patients, more personnel per 100 patients are required than ever before. This must be accepted in setting annual budgets. Parkinson points out that there is no relationship between the amount of work to be done and the number necessary to accomplish the work. Whether or not Parkinson's Law applies here, namely, that it takes about six per cent more people to do the same work each year, is a moot point. Nevertheless, skilled help,—nurses, dietitians, medical record librarians, technicians, physiotherapists, nursing instructors, et cetera—are in short supply and we must be prepared to pay what it takes in open competition. A reduction in numbers or in quality of the personnel in most categories cannot but affect the quality of patient care. Poor nursing can be disastrous; inadequate supervision of special diets could cost a life; wrong laboratory findings are much worse than none at all. Automation is desirable up to a point but it is not the full answer. Tender loving care (TLC) and skilled care will always be necessary.

Combining duties is justified if over departmentalization has been in effect, but not to the point where it means skimping of attention or a high personnel turnover. Cheaper food can be served but it is poor economy if it annoys patients and weakens public relations. Some so-called "efficiency experts" from industry must appreciate that solutions which may work in some industries are not the answer in the quite different hospital field.

Expenditures of Questionable Value

In our frenzied efforts to be modern and up-to-date, it is possible for us to discard a perfectly good and costly machine in favour of one with some new gadget attached and a still higher price tag —because of a theoretical advantage which may prove to be of little practical value. We have all seen expensive equipment, purchased in great enthusiasm, set aside after a brief period because it did not live up to expectations.

Sometimes where a piece of equipment is obviously required, for example, an operating table or an orthopaedic table, we may order the "super-de-luxe" model with all the attachments, yet not have anyone on the staff doing work that requires these extra gadgets. Or we may buy some unusual and very costly piece of laboratory equipment, yet balk at paying the salary of the technician needed to use it accurately.

A small hospital within a few hours of a large city hospital should not feel obligated to buy equipment or provide facilities rarely needed and which requires operation or interpretation by a specialist. The patient would be better served if transferred to a place where such equipment is in constant use. Do not buy more than you can properly use—or afford to use. The medical staff, in requesting new models, new equipment and new drugs, should be able to assure management that the expenditure of these sums of money will really improve the quality of care.

How Can We Evaluate Efficiency?

A basic problem for hospital boards and all concerned with good care and economical efficiency is to evaluate "efficiency".

We can say at once—by results, of course. But that is not very easy when it comes to medical results. The better the reputation of a hospital and its staff, the more likely it is to get the serious and actually hopeless cases. Some of our best surgeons have comparatively poor records when contrasted with other surgeons not in their class, simply because they are brave enough to tackle the most unpromising and hopeless cases while the other fellow only operates on simple cases almost certain to survive even his surgery.

The provincial pathologist in one of our provinces told me on one occasion that the doctor in a very small rural hospital had taken out more appendices over a period of time than had been taken out in the same time by all of the surgeons on the staff of the biggest hospital in that province! As the vast majority of these appendices were

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Staff of the Nightingale School of Nursing, Toronto

Seen here are the seven nurse instructors of the new school, discussing plans with its director, Mrs. M. Blanche Duncanson. Following the pattern set by the Windsor pilot project (1948-53), the Nightingale School will prepare students as fully-fledged Ontario-registered nurses under a 2-year basic program. The instructors are: front row (left to right) Nancy Wartman; Mrs. Duncanson; Joan Macdonald; and Josephine Flaherty. Back row: Heidi Yamashita; Jean Bates; Frances Jolliffe; and Dzidra Voltners.

(see page 36)

Special Problems of the Smaller Hospital

– with fewer than 75 beds

Sr. Mary of the Trinity,
Inverness, N.S.

HEREIN I hope to give you some idea of the problems of a small hospital. My own experience is in a general hospital which will comfortably accommodate 32 adult patients. Most of the time we have 36, sometimes more. Last year our statistics showed 101 per cent occupancy whereas 85 per cent is considered normal. Our extra 16 per cent meant a great deal of work in placing cots in every available space for emergency admissions. This I think is our number 1 problem. No doubt some hospitals of comparable size, but better architecture, have not the same difficulties, as we have. Others may have problems not mentioned here.

Medical Staff

The problem is that of keeping the doctors interested in their obligations as members of the staff. This may apply only to hospitals in small towns. We have three doctors on our staff. One difficulty is in attaining regular staff meetings. With such a small staff there must be 100 per cent attendance for a meeting. Our doctors serve a large rural area and have to drive many miles on calls, consequently it is very difficult to set a time and date for their monthly meetings. They all work together and know the treatment and prognosis of each patient and will already have had consultations over the cases which will be presented at their meeting. They can see no advantage to the patient or themselves in having further discussion, although this is necessary to maintain hospital standards. Another difficulty is departmental assignments. How can you appoint a committee to head each service with only three doctors on your staff? The same applies to medical audits. Our doctors are giving excellent service to their patients but our difficulty in administration is to keep them interested in hospital standards.

Laboratory and X-ray Technicians

Small hospitals are considered fortunate if they have one registered technician in each of these categories. According to the regulations of their respective associations, they work a forty-hour week. However, the public have not yet been trained to keep well from Friday until Monday and after 4 p.m. to 8 a.m. Small towns as well as cities have more highway accidents on weekends, holidays and evenings. Many times our technicians are called for emergency work. Can we expect to keep them under such circumstances when they are free to work in larger centres, have less responsibility and rotation for emergency calls? I should like to hear how other hospitals of comparable size and locality have met this problem, where normally there is not enough work for more than one technician. We cannot expect our girls to be on call 24 hours a day, seven days a week, 52 weeks a year. Can assistants or aides be trained to do the more simple tasks in those departments? If so, who should be responsible for training them? Certainly not the one technician employed in the small hospital. There are many more problems in the above departments. To quote a few: doctors may have to wait 24 to 36 hours for x-ray, cardiology, tissue and sensitivity reports. This often means the patient has to wait that length of time before getting the proper medication or remedy. The same applies when preparing a patient for major surgery. If blood is required it takes three to four days from the time the requisition is made until the blood arrives from the central depot. A few months ago we tried to get a blood bank in Inverness but were refused because we could not give 24-hour laboratory service. I think all this should be taken into consideration when statistics show the average patient-stay to be longer in our small hospitals.

Nursing Service

Obtaining and maintaining sufficient staff is a problem all hospitals have. This I believe is more acute in the small hospital. With the exception of a few who, due to their civil status, have permanent residence in the community, the turnover in this department creates quite a problem for the administrator and those in charge of nursing service. The social life in a small town is not conducive to luring young people; therefore, as a rule, they remain only until they earn enough money to take them to greener pastures. The fact that they are with you not by choice but due to circumstances does not tend toward their giving their best in service. Again they are working at a disadvantage. Today the trend in nursing is segregation of the different services and intensive care for the acutely ill, recovery rooms, et cetera. We are aware of the benefit of this but, in our hospital, we find the best we can do is to keep obstetrical, surgical and medical patients in separate departments. This entails more precautions such as surgically aseptic techniques. Still I think many of the older nurses will agree that, in the days before antibiotics when the nurses made more use of soap, water and antiseptics, we had fewer cases of cross infections than we have today. If a nurse intends to remain at her profession for some years, she takes a post graduate course in some field of nursing in which she is especially interested. Naturally when she is finished she will be assigned or accept a position in the type of work for which she is equipped. The smaller hospital cannot hope to interest her even if it could afford to.

The problems in dietetics and housekeeping are similar to those in other departments. Lack of personnel. Young girls with no previ-

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Sr. Mary of the Trinity is administrator of Saint Mary's Hospital, Inverness, N.S. This paper was presented at the annual meeting of the Maritime Hospital Association, June, 1960.

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Hospital Accreditation

— its principles and importance

E. N. Boettcher, M.D.,
Victoria, B.C.

THE principles of accreditation simply require that a hospital be designed and organized for the benefit of the patient. Briefly they are as follows:

The buildings of the hospital must be constructed to ensure the safety and welfare of *the patient.*

The governing body is legally and morally responsible, through the administrator, for the conduct of the hospital as an institution serving the community and *the patient.*

The medical staff is responsible for the quality of medical care rendered to *the patient.*

Professional nursing care must be available at all times for *the patient.*

There is one thing common to all four of these basic principles and that is the patient. The accreditation surveyor is primarily concerned with the patient's care and surveys the hospital from the standpoint of whether or not it is providing the facilities, the organization, and the services essential to meet the needs of the patient.

While the governing body has the ultimate responsibility for the conduct of the hospital, the managerial or administrative functions are delegated to the administrator, and the responsibilities for professional care of the patient are delegated to the medical staff. It should be emphasized that the medical staff is the only appropriate body to which responsibility can be delegated for supervision and advisory functions in respect to professional and medical care of the patient. Only as the medical staff is properly organized, with its own officers and committees, can it carry out this responsibility adequately and to the satisfaction of the governing body and the accreditation surveyor. As one accreditation surveyor put it to me, one of the purposes of accreditation is to make certain that all aspects of medical care are, in fact, under medical supervision.

Accreditation should not be considered as a device which will ensure control of the medical staff, but, rather, as one to ensure that the medical staff are controlling the activities in the hospital which are concerned with medical care.

Advantages

1. The first advantage in obtaining accreditation, in my opinion, is the assurance it renders to those of us working within the hospital that we are, in fact, meeting the basic minimum standards, that we are providing good-quality patient care and that we are showing signs of improvement as time goes on. It is very important that we should not become complacent about the quality of our work and a survey by a representative of the Council on Accreditation can be an excellent stimulus to keep us on our toes.

2. The second main advantage of accreditation is that it gives assurance to the community which we serve that it has the benefits of a hospital which is fully accredited. We are all aware of the importance of keeping the public informed and of maintaining the confidence of the community in the hospital. Furthermore, the public is asking more and more often whether they are receiving full value for their dollar in the field of hospital care. Full accreditation is one of the best answers available to date to this question.

3. Further to the first and second reasons mentioned, I would add the fact that an accreditation survey can be of considerable assistance to the board, the administrator, and the medical staff in their endeavours to evaluate the adequacy of the work they are doing. Every accreditation survey results in a number of recommendations to the hospital on areas in which there is room for improvement. Such advisory service at no additional cost to the hospital can be very valuable if fully utilized.

4. When we review the composition of the Canadian Council on Hospital Accreditation, we can see that it provides a very useful mechanism for liaison between hospital and medical groups at the national level. I think we are all aware of the importance of team work in the health field at all levels, local, provincial and national, and the Accreditation Council is certainly an excellent example of such team work.

5. Possibly, one of the most important reasons for continuing support of the principle of accreditation is the fact that it is a completely voluntary endeavour. We know that the government is participating more and more in the policy decisions and general activities in the field of health, even though government may be responsible for providing the mechanism for financing hospital care. I feel that the matter of maintaining standards and evaluating those standards should be kept in the control of the professional and hospital people themselves. The accreditation program is just that and, to date, we have received every encouragement from government at both the national and provincial levels, urging hospitals to participate in this program. If we ourselves are responsible for the establishment and functioning of the accreditation program and if we voluntarily make the necessary effort to obtain full accreditation from the Canadian Council on Hospital Accreditation, we are, in fact, retaining our voluntary initiative and *autonomy* in the realm of standards of patient care.

I think it is appropriate for everyone in any community, both those working in the hospital and those who are not directly as-

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From an article by Dr. E. N. Boettcher presented at the Regional Conference of Vancouver Island Hospitals, B.C. Dr. Boettcher is medical superintendent, St. Joseph's Hospital, Victoria, B.C.

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Why Queensway is Adopting

PROGRESSIVE PATIENT CARE

H. F. Garwood,
Toronto, Ont.

THE nature of hospital care has changed many times during the centuries past and undoubtedly will change in the future. The public is more health conscious and more cost conscious than ever before; and these two factors are bringing the operation of hospitals under critical review.

At the Queensway General Hospital, we believe that a system of progressive patient care can satisfy an enlightened public on both counts — providing the best possible care at the lowest costs. To achieve such a system will not be easy but we are convinced that the improvements which we expect to follow its introduction warrant the considerable effort necessary. I would here suggest to anyone who is considering a program of progressive care that there are two prerequisites basic to its success. These are: (a) a medical staff which demonstrates a high degree of co-operation within their own organization and with all other hospital groups; and (b) a board of governors and administrator with real enthusiasm for the system.

In the traditional hospital, patient care is given in wards which are planned and operated according to the general branch of medicine in which the disease or disability arises. In terms of the critically ill, the facilities and services are sometimes inadequate; whereas for the patient who is well on the way to recovery, these same facilities may be far more than is required. In the hospital which has progressive patient care, care is organized primarily according to the medical and nursing needs of the patients.

Benefits to the Patient

At the risk of repeating, under progressive patient care the patient receives the kind of treatment he needs when he needs it. This may sound simple but it actually implies a comprehensive range in both type and quantity of treatment. The patient who is critically ill is given constant care and attention. All the life-saving equipment and supplies are conveniently stored within the nursing unit. The nurse in attendance is especially trained to recognize quickly the signs of changing conditions and will carry out the physician's orders immediately. In such an area visiting may be restricted or eliminated entirely. This means that no one patient will be disturbed by the noise made by visitors to another who may be feeling quite well. The critically ill patient thus receives the equivalent of private duty nursing—but with an important difference—the nurse is especially trained. As one of our medical staff members remarked, without meaning to cast any reflection on the good job done by nurses, "this type of patient is really too sick for a private duty nurse."

Employee Selection and Orientation

As industry has found that different work requires people of different skills so, under progressive patient care, we recognize that different forms of patient treatment require employees, especially nurses, of varying capabilities. Not all nurses like or are trained for the tense drama of the intensive care unit. By the same token, those who do not fit in there may be ideally suited, by virtue of training and personality, for the educational and guidance rôle associated with rehabilitation or long-term care.

As the administrator of the Manchester Memorial Hospital, Manchester, Conn. (which we visited) remarked: "Our progressive patient care program has enabled us to fit square pegs into square holes." Application of this basic principle may well result in improved morale and higher productivity. It is obvious that it permits better use of the professional nurse's time and talents; and if generally applied it could be an important factor in helping to remedy the shortage of nurses.

Physical Facilities

Planning each unit of progressive patient care according to the functions being performed within that unit presents an opportunity to take a fresh look at the layout and design of hospitals.

Is it necessary to provide elaborate facilities and service in the rooms of most ambulatory patients? We think not. A survey of the patients in our hospital, conducted by a committee of the medical staff, indicated that at least 20 per cent of all patients could be cared for in a self-care unit. The doctors determined that these patients were able to walk unattended to the cafeteria and get their own meals, to walk to the nurses' station for medications and to the various departments for test and treatment. The savings in employee time are obvious and, psychologically, it is thought better for patients to carry out these activities.

It is possible in a self-care unit to simulate the atmosphere of the average home, like that to which the patient will be returning after a serious illness. His ability to look after himself at home can be determined while he is still in hospital; and his confidence in being able to do this, when discharged, can be developed before he leaves the protective and organized atmosphere of the hospital. To some persons this idea suggests a longer stay. Actually the reverse could well be the case. At the Manchester Memorial Hospital the average day's stay was significantly lower than in other hospitals.

Speaking generally, the institution of progressive patient care means, again, classifying patients according to their needs. In addition to the 20 per cent at our hospital who might well be in the self-care category, studies showed that ten per cent required intensive care, with the remaining 70 per cent falling into either the intermediate or long-term category. Because of the existing or proposed facilities in our community, few beds for long-term care

(continued on page 108)

The author is administrator of the Queensway General Hospital, Toronto, Ont.

Sr. Ste. Agathe-de-Jésus

Jean Jacques Laurier, M.D.

Arthur H. Hewig

Sr. Marie de Loyola

Sr. Rachel Tourigny

Sr. Corinne Kerr

The A.C.H.A. holds its annual convocation

AT ITS 26th annual convocation ceremony, held on August 28th, the College conferred certificates of fellowship upon 147 members, advanced 281 nominees to membership and admitted 323 new nominees. The convocation was held in the Masonic Memorial Temple in San Francisco.

At the same ceremony, the College conferred its highest commendation, honorary fellowship, upon four distinguished leaders in the health and education fields. They are: F. J. L. Blasingame, M.D., executive vice-president, American Medical Association, Chicago; Ward Darley, M.D., director, Association of American Medical Colleges, Evanston, Ill.; Professor Marshall E. Dimock, New York University, New York City; and Lt. General Leonard D. Heaton, M.D., the Surgeon General, Department of the Army, Washington, D.C.

At the annual banquet, which followed the convocation by a few hours but which was held in the Garden Court of the Sheraton-Palace hotel, Ray E. Brown, A.C.H.A. president, presented an address highlighting salient achievements and pointing out directions for future growth and development of the professional society. The Arthur C. Bachmeyer Memorial Address, customarily delivered at the annual banquet, was re-scheduled for the forthcoming Fourth Annual Congress on Administration to be held in Chicago between February 2-4, 1961.

The traditional past-president's emblem was given to Anthony W. Eckert, director of the Perth Amboy General Hospital in New Jersey, who served the college as its president between 1958 and 1959.

Canadians honoured at the convocation ceremony are listed below:

Fellows

R. Ray Copeland, administrator, The South Peel Hospital, Cooksville, Ont.

Vera Beatrice Eidt, assistant administrator and director of nursing service, Campbellford Memorial Hospital, Campbellford, Ont.

Sr. Frances Corinne Kerr, regional supervisor of hospitals, Sanatorium Notre-Dame de Lourdes, Vallée Lourdes, N.B.

Arthur H. Hewig, administrator, Sarnia General Hospital, Sarnia, Ont.

Jean Jacques Laurier, M.D., medical director, Ottawa General Hospital, Ottawa.

Sr. Marie de Loyola, administrator l'Hôtel-Dieu de l'Assomption, Moncton, N.B.

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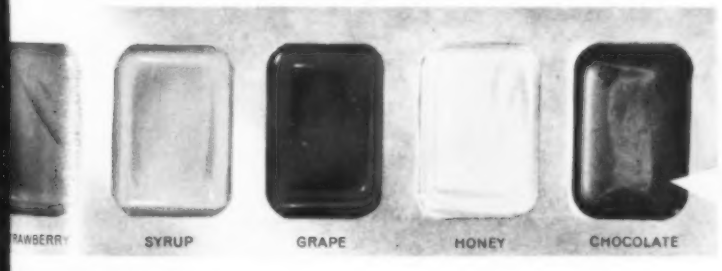

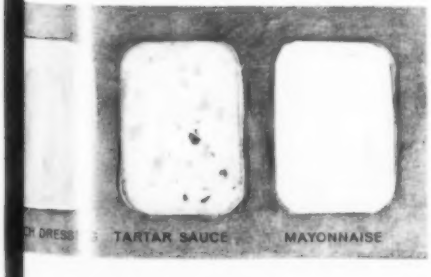

menu-planners' PC CHECK-LIST

Jams and Jellies	Apple, Mint-Flavored Apple, Grape, Currant, Strawberry, Black Raspberry, Orange Marmalade, Cranberry Sauce	For Toast, Sandwiches, Entrees
Condiments	Mustard, Ketchup	For Burgers, French Fries, Sandwiches
Dressings	French, Miracle Whip Salad Dressing, Mayonnaise, Tartar Sauce	For Salads, Fish
Toppings	Caramel, Chocolate, Strawberry	For Ice Cream Sundaes, Desserts
Syrups	Maple-Flavored Syrup; Honey	For Waffles, Pancakes, Chicken
20 PCs per tray	10 Trays to a carton (Syrup is 5 trays per ctn.)	With PCs you control costs, portions and quality

Sr. Ste. Agathe-de-Jésus

Jean Jacques Laurier, M.D.

Arthur H. Hewig

Sr. Marie de Loyola

Sr. Rachel Tourigny

Sr. Corinne Kerr

The A.C.H.A. holds its annual convocation

AT ITS 26th annual convocation ceremony, held on August 28th, the College conferred certificates of fellowship upon 147 members, advanced 281 nominees to membership and admitted 323 new nominees. The convocation was held in the Masonic Memorial Temple in San Francisco.

At the same ceremony, the College conferred its highest commendation, honorary fellowship, upon four distinguished leaders in the health and education fields. They are: F. J. L. Blasingame, M.D., executive vice-president, American Medical Association, Chicago; Ward Darley, M.D., director, Association of American Medical Colleges, Evanston, Ill.; Professor Marshall E. Dimock, New York University, New York City; and Lt. General Leonard D. Heaton, M.D., the Surgeon General, Department of the Army, Washington, D.C.

At the annual banquet, which followed the convocation by a few hours but which was held in the Garden Court of the Sheraton-Palace hotel, Ray E. Brown, A.C.H.A. president, presented an address highlighting salient achievements and pointing out directions for future growth and development of the professional society. The Arthur C. Bachmeyer Memorial Address, customarily delivered at the annual banquet, was re-scheduled for the forthcoming Fourth Annual Congress on Administration to be held in Chicago between February 2-4, 1961.

The traditional past-president's emblem was given to Anthony W. Eckert, director of the Perth Amboy General Hospital in New Jersey, who served the college as its president between 1958 and 1959.

Canadians honoured at the convocation ceremony are listed below:

Fellows

R. Ray Copeland, administrator, The South Peel Hospital, Cooksville, Ont.

Vera Beatrice Eidt, assistant administrator and director of nursing service, Campbellford Memorial Hospital, Campbellford, Ont.

Sr. Frances Corinne Kerr, regional supervisor of hospitals, Sanatorium Notre-Dame de Lourdes, Vallée Lourdes, N.B.

Arthur H. Hewig, administrator, Sarnia General Hospital, Sarnia, Ont.

Jean Jacques Laurier, M.D., medical director, Ottawa General Hospital, Ottawa.

Sr. Marie de Loyola, administrator l'Hôtel-Dieu de l'Assomption, Moncton, N.B.

GRIDDLE GLORY: Pancakes rate high on the menu when they're made light and thin, and wrapped around Kraft Cream Loaf whipped to airy smoothness. Serve with Kraft PC Table Syrup.

TASTY FOURSOME: Two pairs on a plate that customers "go for"—a Kraft Ketchup PC for the french fries and a Cranberry Sauce PC for the fried chicken.

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easily solved by Kraft PCs

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You'll surely find these Kraft food packets just as profitable for you! With PCs, you readily control portions and costs with a minimum of supervision. And the new zip-off top on PCs adds extra convenience to these extra-good Kraft foods.

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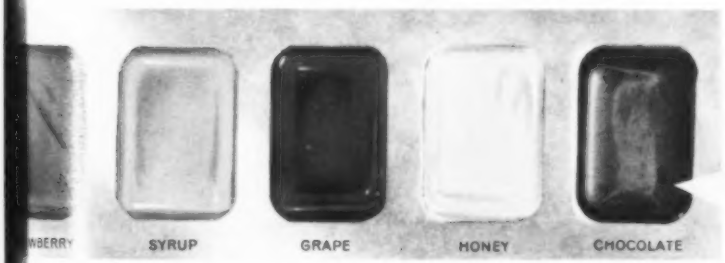

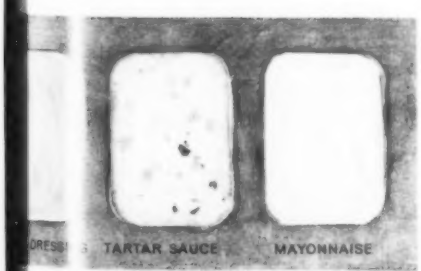

menu-planners' PC CHECK-LIST

Jams and Jellies	Apple, Mint-Flavored Apple, Grape, Currant, Strawberry, Black Raspberry, Orange Marmalade, Cranberry Sauce	For Toast, Sandwiches, Entrees
Condiments	Mustard, Ketchup	For Burgers, French Fries, Sandwiches
Dressings	French, Miracle Whip Salad Dressing, Mayonnaise, Tartar Sauce	For Salads, Fish
Toppings	Caramel, Chocolate, Strawberry	For Ice Cream Sundaes, Desserts
Syrups	Maple-Flavored Syrup; Honey	For Waffles, Pancakes, Chicken
20 PCs per tray	10 Trays to a carton (Syrup is 5 trays per ctn.)	With PCs you control costs, portions and quality

Vera B. Eidt

R. Ray Copeland

Mother St.-Adolphe

Brock H. Payne, administrator, Brantford General Hospital, Brantford, Ont.

Sr. Rachel Tourigny, administrator, l'Hôpital Saint-Jean, St-Jean, Que.

Mother St-Adolphe, supérieure, l'Hôtel-Dieu de Québec, Que.

Sr. Ste. Agathe-de-Jésus, administrator, l'Hôtel-Dieu de Levis, Levis, Que.

Eugene Thibault, M.D., medical director, l'Hôpital Général de Verdun, Verdun, Que.

Edwin V. Wahn, assistant director, University Hospital, Saskatoon, Sask.

Members

Sr. M. Clotilde, administrator, St. Mary's General Hospital, Kitchener, Ont.

Mary L. Finger, assistant administrator, Women's College Hospital, Toronto, Ont.

Sr. M. Janet, superintendent, St. Michael's Hospital, Toronto, Ont.

Paul Laplante, M.D., directeur général, l'Hôpital Saint-Luc, Montreal, Que.

Robert J. Long, administrator, Northwestern General Hospital, Toronto, Ont.

Sr. Lucienne Lapierre, administrator, Maisonneuve Hospital, Montreal, Que.

Sr. Maille, provincial superior, Maison Provinciale, Montreal, Que.

Sr. Mary Albert, administrator, Mineral Springs Hospital, Banff, Alta.

Sr. Mary Margaret, administrator, Hotel Dieu Hospital, Kingston, Ont.

Albert Nantel, administrator, l'Hôpital Ste Jeanne d'Arc, Montreal, Que.

William O'Neill, administrator, Joseph Brant Memorial Hospital, Burlington, Ont.

Sr. M. Patricia, administrator, St. Joseph's General Hospital, Port Arthur, Ont.

Joseph A. Ritchie, administrator, Brome-Missisquoi Perkins Hospital, Sweetsburg, Que.

C. A. Sage, associate director, The Hospital for Sick Children, Toronto, Ont.

Edward Wilson, M.D., medical superintendent, Nora-Frances Henderson Hospital, Hamilton, Ont.

James G. Wilson, general superintendent, Brockville General Hospital, Brockville, Ont.

Nominees

Guy Allard, coordonateur des cliniques externes, l'Hôpital Ste-Jeanne d'Arc, Montreal, Que.

Sr. Ann Martin, assistant administrator, St. Rita Hospital, Sydney, N.S.

Major G. T. John Barrett, administrative officer, Canadian Forces Hospital, Kingston, Ont.

(concluded on page 88)

Brock H. Payne

Eugene W. Thibault, M.D.

Edwin V. Wahn


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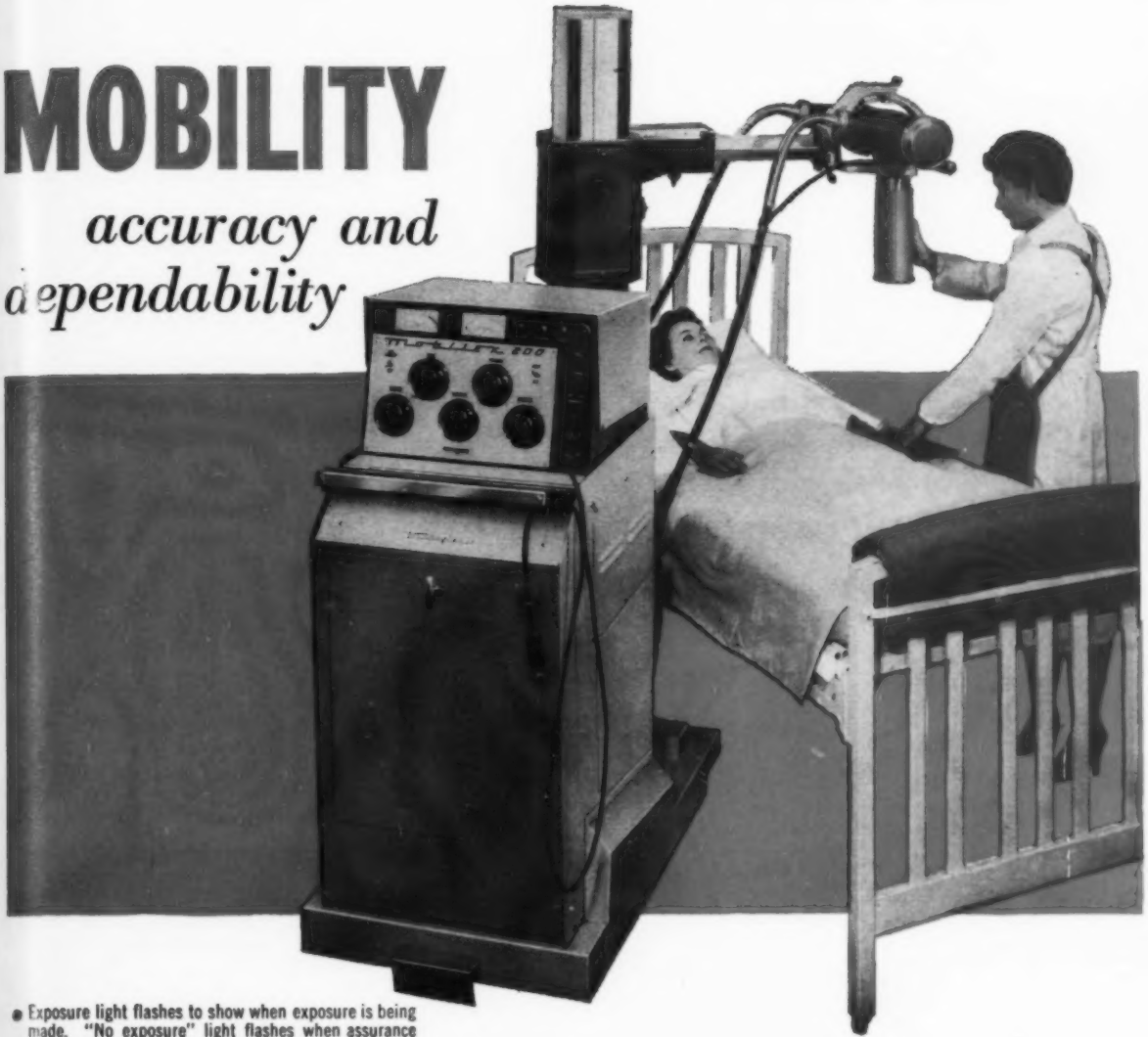

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With the Auxiliaries

$7,500 Laundry Machinery Installed

Two pieces of laundry machinery have been installed in the Groves Memorial Community Hospital in Fergus, Ont., the funds for which were donated by the women's auxiliary of the hospital. The total cost of the equipment will be close to $7,500, of which $6,300 has already been paid. One of the machines is a huge, gas-fired ironer, which is capable of handling sheets at the rate of 30 feet per minute. A spin extractor was the other machine donated by the auxiliary.

Successful Festival at Surrey

The Ladies' Auxiliary of Surrey Memorial Hospital, Surrey, B.C., joined by its 14 branches, sponsored a successful festival on the hospital grounds. The reeve of Surrey opened the festival and bazaar, commending the ladies for their outstanding work. Many and varied features such as a "cake walk", white elephant table, fish pond for the youngsters, display of plants and cut flowers and a mystery prize table attracted a large number of visitors. The $764.42 raised at the festival will be put in the general fund of the auxiliary.

Equipment for the Supply Room

The Junior Hospital Auxiliary at the Kootenay Lake General Hospital in Nelson, B.C., donated funds recently to the new hospital which were used to purchase equipment for the central supply room. The much needed stainless steel dressing jars, sterile solution flasks and other instruments were obtained.

Money from Lumbago Belts

A source of funds for the Ladies' Auxiliary of the Kimberly and District Hospital in Kimberly, B.C., is from the sale of lumbago belts which are made by the auxiliary for the local mine employees. The auxiliary has also been able to raise some money from the sale of home baking, hand made aprons and a variety of bazaar articles. A third source of funds is the annual association membership drive. Through these various activities the auxiliary has been able to donate $1,000 to the hospital which will be used to furnish a two-bed ward in the new hospital.

Thrift Shop Thrives

A small cabin in the centre of Burns Lake, B.C. was the original site of the Thrift Shop operated by the Burns Lake and District Hospital Women's Auxiliary, but due to the great activity of the shop, it now occupies larger premises. The shop is open every Saturday afternoon and the success of it depends on the response of the public, which has been encouraging.

Donations of clothing and usable goods of all kinds have been received from as far away as Ontario and California. The shop pays postage and freight on in-coming parcels and covers the operating expenses.

The net profit from the shop up to date is $7,513.25 and the auxiliary has financed most of its donations to the hospital through the shop. The auxiliary has been able to donate $4,500 to the building fund for the new hospital. A "meal on wheels" has also been purchased. The latest gift is the equipping of a four-bed public ward at a cost of close to $1,840.

Entertainment Night

Patients both young and old, at the Memorial Hospital in Sudbury, Ont., enjoyed an Entertainment Night, sponsored by the Women's Auxiliary. A group of young artists from the arts guild of New Sudbury provided a program of tap dances, ballet numbers and modern dance routines. The evening was enjoyed just as much by the young dancers who were giving the program as by the patients who were watching it.

Auxiliary at Branson in Full Activity

The recently formed Women's Auxiliary of the North York Branson Hospital in Willowdale, Ont., is already planning money-raising activities in preparation for further expansion of the hospital. The new gift shop, opened only this summer, is proving an important source of funds. Members of the auxiliary visit the wards and relieve the nurses of duties where nursing skill is not required. They provide books for patients, do errands around the hospital and outside and also baby-sit in the lobby for hospital visitors.

$1000 to Hospital Fund

A $1,000 cheque was presented to the superior of St. Mary's General Hospital in Kitchener, Ont., at the meeting of the hospital auxiliary. This is the second $1,000 contribution the group has made towards its pledge for the building fund. A balance of $10,800 has yet to be raised.

Successful Barbecue at Williamsburg

A considerable number of people attended a chicken barbecue sponsored by the Williamsburg Unit of the District Memorial Hospital auxiliary and funds raised will go towards furnishing a room at the hospital. The auxiliary expects to net more than $200 from the affair. During the barbeque the visitors enjoyed a softball game.

For Meeting and Eating

A restaurant at the Youville Hospital in Noranda, Que., operated by the women's auxiliary has become more than just a place for eating for the patients and the staff. The restaurant provides a meeting place for walking patients and their children, since it is impossible to allow children to visit in the wards. The restaurant also sells gifts and comforts suitable for the patients.

14th Annual Meeting of Auxiliary

A $3,000 cheque for shortwave equipment was presented to St. Joseph's Hospital in Hamilton, Ontario, by the auxiliary at its 14th annual meeting. The meeting was addressed by Dr. Charles H. Jaimet, chief of medicine at the hospital. The annual scholarship in nursing was also presented by the auxiliary.

Operation Friendship

The White Cross Volunteers in Richmond Hill, Ont., this year formed a society named Operation Friendship under the auspices of the Canadian Mental Health Association. The society devotes its time to the rehabilitation of the patients in the Park Avenue Home.

Smallpox in the World in 1959

About 72,000 cases of smallpox were officially notifed to the World Health Organization in 1959, against some 242,000 in 1958. This decrease of the world incidence is due to the improvement of the situation in India and East Pakistan where, during the exceptionally unfavourable year of 1958, the total number of cases reached 218,000 but fell to 50,000 in 1959. —*World Health*

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STEROX-O-MATIC!
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WRITE for CES Bulletin 0775-2, showing hospital savings through Steroxcide glove sterilization and detailing step-by-step sterilizing procedures.

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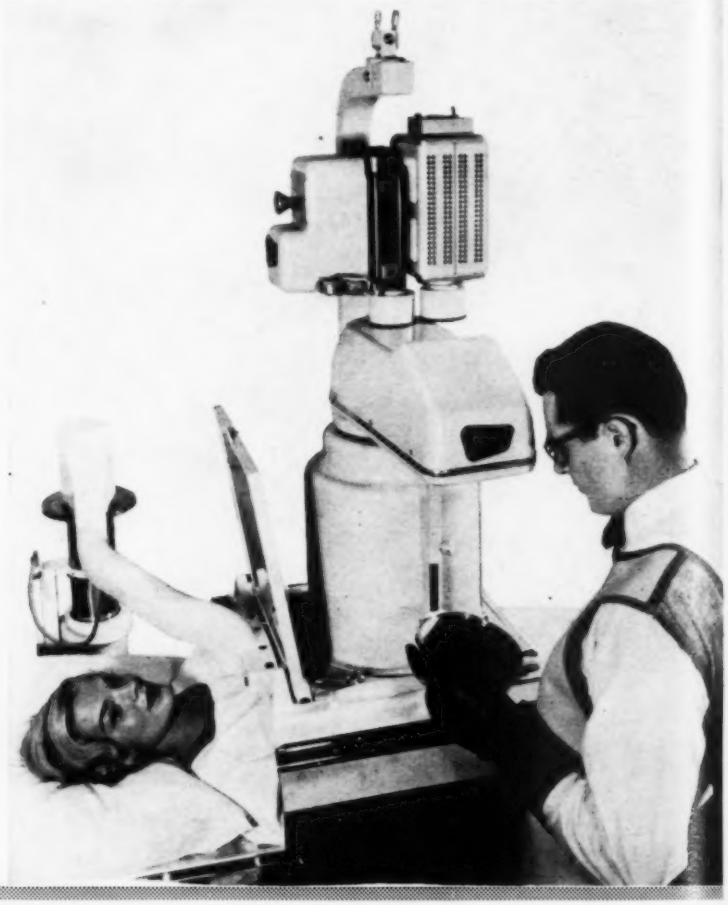

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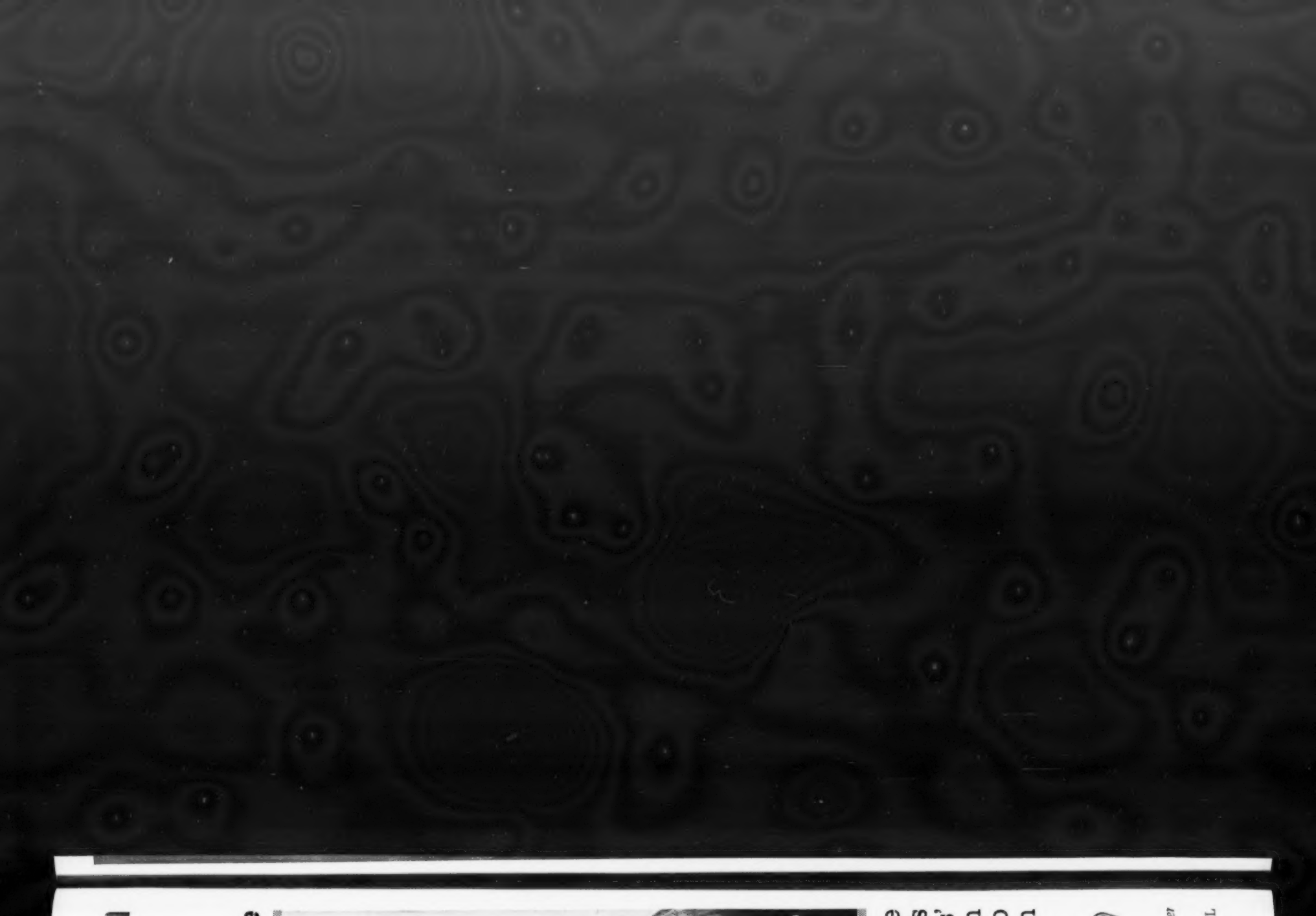

Letters to the Editor

Dear Mr. Editor:

As one of the Vancouver General Hospital nurses who participates in a group subscription to the "*Canadian Hospital*", may I say how very worth-while I find this journal. I feel the articles are a considerable help to people in every department of the hospital, but most certainly are of interest to the nursing profession. In the April, 1960, issue I found especially pertinent the series of articles on the facilities for the senior citizens. Also, in the January, 1960, issue I was particularly happy to see the new Kootenay Lake General Hospital at Nelson, B.C., and nurses' residence at Archer Memorial Hospital, Lamont, Alberta. I would like to order a copy of the January, 1960, issue.

(signed)
Norma Dick,
Supervisor of Inservice Education.

Welcome Bags at Cornwall General

Dear Mr. Editor:

About three months ago this hospital began a project of supplying a Welcome Bag of necessities used in hospital and placing it at the bedside just prior to the patient's arrival. We cannot claim that this is original with us, but we found it a very valuable public relations gesture.

This bag contains such items as celluwipes, hand lotion or back rub, soap, stationery, a pencil with the hospital's name on it, a variety of pamphlets regarding hospitals, Hospital Commission regulations, and a letter of greeting from the administrator. All of these contents are placed in a pliofilm bag which is tied at the top and to which is attached a tag which says "Welcome to the Cornwall General Hospital".

Another public relations aspect of this is that these bags are packed for us by one of our women's auxiliaries and by two different packs of Girl Guides and by some high school students. In this way we obtain volunteer services and also add a slight personal touch to the admission of the patient to the hospital.

For your interest I am sending forward a sample bag, and I thought that you might like to mention this in one of your Journal issues as a possible public relations gesture by another hospital.

(signed)
F. H. Silversides
Administrator

Questionnaire in Patient's Folder

Another hospital providing a welcome for incoming patients, this time in the form of a plastic folder, is Mineral Springs Hospital, Banff, Alberta. The folder contains various pamphlets stating facts the patient needs to know. *A Memo for Visitors* with humorous illustrations, asking for the visitor's co-operation, is also included. Another pamphlet provides interesting background information on the Mineral Springs Hospital and the Sisters of St. Martha, who conduct the hospital.

Patient's comments about their experience in the hospital are invited in the form of a small pamphlet entitled "We wish we could x-ray your opinion." This contains a brief questionnaire with some pages left blank for additional comments. The questionnaire, requiring no signature to encourage patients to express candid opinions, is sent straight to the administrator.

New Swimming Pool for Nurses

A new outdoor swimming pool for nurses and student nurses at the Jewish General Hospital, Montreal, Que., was officially opened last month. The pool was donated by members of the hospital's board of administration and was received on behalf of the school by the director of nursing, Joan Gilchrist. It is situated just behind the nursing school.

Twenty Years Ago

From the Canadian Hospital September, 1940.

Bronze Buffalo to Dr. Stephens

A bronze buffalo standing o a base of Manitoba marble was re-sented to Dr. George F. Steph ns prior to his departure from Wi nipeg at a dinner tendered to hin by over one hundred of the trus es and doctors with whom he has b en associated at the Winnipeg Gen ral Hospital. In making the prese ta-tion, Mr. Sellers stated, "Dr. Stephens has done a great job for the hospital and has been a g eat citizen." Dr. George S. Fah ni, president-elect of the Canadian Medical Association, presided. The Manitoba Hospital Association also tendered a luncheon prior to his departure.

A New Form of Public Service

St. Mary's Hospital at Timmins has extended its public relations into a unique field. Last week a provincial constable stopped a motor car near one of the gold mines in that district. Suspecting that the passengers might be high-graders, the constable slipped a tight elastic band around the bottom of the trouser legs of the men and took them to St. Mary's Hospital, where they were put under the screen by Dr. Norman Russell. The x-ray revealed metal capsules, measuring about three inches in length by one and half in diameter and containing high grade gold ore, on the bodies of the men. The capsules and ore are being held by the police as exhibits for the forthcoming trial.

Canadian Army Doctors Entertained by Middlesex Hospital

The *Lancet* recently noted the hospitality extended to Canadian medical officers by the Middlesex hospital. The Canadian officers visited the hospital in groups of about 20, and the program planned for them was in the nature of a brief "refresher course". The Earl of Athlone appeared at the hospital one afternoon and took tea with the Canadian officers shortly before he left England for Canada.

At Moose Factory, near James Bay, last summer a white whale was killed on the shores of the island. Two hundred pounds of this were procured by the hospital and put in the deep freeze. The flesh looked like very dark liver. This meat is served to the Eskimo patients as a special treat.—*Nutrition Notes*

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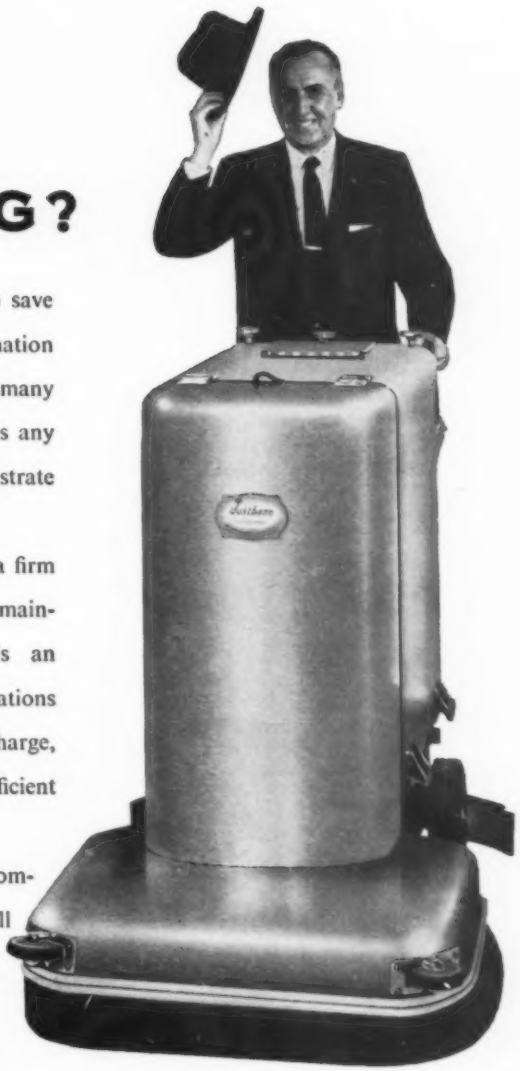

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Book Reviews

CURRICULUM DEVELOPMENT by Amy Frances Brown, R.N., B.Ed., M.S. in N., Ph.D. Published by W. B. Saunders Company, March, 1960. Illus. Pp. 851. Price $10.00.

This book is a revision and expansion of the first six units of the author's book, *Clinical Instruction* (1949, W. B. Saunders Co.). The present volume is divided into eight sections discussing: one, the nature of an educational program (introduction); two, major tasks in curriculum development; three, foundations of the nursing curriculum; four, teaching in the hospital divisions; five, planning a course; six, clinical instruction and experience; seven, aids to learning; and eight, research in curriculum development. Special articles are contributed to the book by individuals well known in their separate fields. Generally the book is copiously documented with suggestions for further reading given at the end of each section.

In the introductory section the author states that the areas in the curriculum which are undergoing particularly significant changes are communication, sciences, and the fine arts. In an increasing number of institutions, the concept of communication has been greatly broadened to include in addition to writing, speaking, reading and listening, other media of expression such as mathematics and the fine arts. She says that there is need in our society for specialists of various kinds but insists that specialization should be preceded by a broad foundation of study, and that the specialist should be aware of the limitations of his preparation.

The author continues to say that during the last decade, there have been two general trends in the character of medical education; one, in the direction of expanding the compartmentalization of teaching by adding to the sum total of knowledge in a particular field and blocking out specific areas, and the second, away from depa t-mentalization and compartme t-alization of medical knowledg a trend which focuses more att n-tion on the patient as a whole r an and leans towards understand ng the psychosocial factors in soc ty which may contribute to he etiology and treatment of dise se.

The author feels that this en-dency to inhibit education out ide the speciality can be particul rly illustrated in the program of ed ca-tion for nursing. The ty; cal student enters a diploma prog am which consists almost exclusi ely of studies and practice (m tly practice in nursing). Accordi ly, Miss Brown has outlined a pat ern for the basic collegiate progra in nursing which consists of our main components: the humani ies, the social sciences, the physical and biological sciences, and the cli ical subjects. The five main branch s of the last are medical nursing, s rgical nursing, paediatric nursing, obstetric nursing, and psychiatric nursing. And all other learning experiences are integrated in these various branches if sufficient thought is given to relating experiences according to the principles of curriculum organization. She insists that in planning a collegiate program of any kind, care should

be taken to provide a program of studies which will contribute to a liberal education.

The author also gives a suggested diploma program for nursing of three years as it is evident that the graduate of any basic program has the same need for competence in clinical nursing as the graduate of the four year college course. She feels that the standards for admission to a diploma program should be fully as rigorous as for admission to a college.

The introduction concludes with certain advice on the two year basic program, supplementary programs for graduates of diploma programs and graduate study for nurses.

This book provides not only a comprehensive résumé of nursing programs to date but also gives a full explanation and treatment of proposed changes in the nursing curriculum.

* * *

PREMATURE BABIES, by A. K. Geddes, M.D. Published by W. B. Saunders Co., Philadelphia and London, 1960. Pp. 215. Price $4.50.

Written as a guide for the nurse caring for the immature infant, this book covers procedure in the delivery room and the nursery, the infections that may be present and also the general planning of the premature nursery. The author stresses that "though it is important for her (the nurse) to know *what* to do, it is vital for her to know *why* she does it". This he shows in a concise and methodical way — there are summaries at the end of each chapter and diagrams are clear and to the point.

* * *

INSTITUTIONAL NEUROSIS by Russell Barton, M.B., M.R.C.P., D.P.M. Published by The Macmillan Company of Canada Limited. Pp. 56. Price $1.45.

In the preface the author states that the purpose of this booklet is to present in a systematic form the dreadful mental changes that may result from institutional life and the steps that can be taken to cure them. He says, "I have confined attention to the material readily available to me in mental hospitals where, unfortunately, there has been a tendency to assume that such mental changes are an end result of mental illness. This is not so . . . It results from factors other than the illness bringing the patient into hospital."

According to the foreword by Dr. Noel Gordon Harris, Dr. Barton has described in his book how with modern progress in some forms of treatment and more knowledge of rehabilitation the patients can be helped infinitely more if only the whole attitude of those who care for the mentally ill be altered towards establishing individual support and friendship.

* * *

PSYCHOLOGY AND THE NURSE by Frank J. O'Hara, C.S.C., Ph.D. Fifth Edition. Published by W. B. Saunders Company, Philadelphia and London, 1960. Illus. Pp. 329. Price $3.75.

In this edition the general plan of the previous editions has been retained. Content and bibliography have been brought up to date, and new diagrammatic sketches and material have been included.

This book presents the principles, materials, methods and facts of psychology of value and service to the nurse. There is a summary, questions for review, topics for class discussion and references given at the end of each chapter. Also each chapter except

(continued on page 106)

Summer Session Students

Second Year Students

The students who attended the second year H.O.M. summer session at the University of Manitoba were as follows: Sr. Adrienne, St. Claude, Man.; Sr. M. Alexina, Radway, Alta.; Sr. M. Angelica, Edmonton, Alta.; Frank G. Baker, Ottawa; Ronald J. Baker, Hamilton, Ont.; Garnet M. Barrow, Prince Rupert, B.C.; John J. Benham, Nanaimo, B.C.; Dr. Marcel Berthiaume, Gamelin, Montreal; Donald A. Biggs, Fredericton, N.B.; William O. Booth, New Westminster, B.C.; Sr. Marie-Thérèse Boulet, St. Boniface, Man.; Alex S. Brown, Toronto, Ont.; Sr. F. Cazabon, Whitelaw, Alta.; Sr. Mary Ann Celesta, Victoria, B.C.; Stewart M. Chapman, Lethbridge, Alta.; Sr. Catherine Charles, Halifax, N.S.; Richard N. Christy, Denver, Colorado, U.S.A.; Elizabeth L. Clement, Victoria, B.C.; Charlotte Cook, Toronto, Ont.; William E. Cooke, Sioux Lookout, Ont.; Dorothy Doan, Strathroy, Ont.; Dr. Christopher J. Doherty, Sudbury, Ont.; Shaun Duffy, Toronto, Ont.; Mrs. Dorotha Edgeworth, Chicago, Illinois, U.S.A.; Mrs. Grace E. Edwards, Digby, N.S.; J. Warren Free, Edmonton, Alta.; Dr. Charles S. Gamble, Nanaimo, B.C.; Sr. Leo Gertrude, Halifax, N.S.; Royce H. Gill, Leader, Sask.; Sr. Lorraine Godin, Perth, N.B.; Norman D. Guy, Moose Jaw, Sask.; Henry E. Heckler, Hamilton, Ont.; Sr. M. Hildegard, Humboldt, Sask.; Bernard Holden, Deep River, Ont.; Dr. Antanas Janauskas, London, Ont.; Gilberte Lanthier, Ottawa; Sr. Aline Leblanc, Sorel, P.Q.; Déo Ledoux, Ottawa; Donald H. Lefebre, Saskatoon, Sask.; Harold L. Livergant, North Battleford, Sask.; Capt. Robert F. R. Livesey, Kingston, Ont.; Gordon S. MacKenzie, Calgary, Alta.; Sr. Monique Marguerite, Montreal, P.Q.; George Morgan, Toronto, Ont.; George E. Mowat, Red Deer, Alta.; Sr. Mary Louise Murphy, St. Catharines, Ont.; Mrs. Margaret O'Brien, Ituna, Sask.; Lawrence J. O'Driscoll, Sault Ste. Marie, Ont.; John J. O'Keefe, Saint John, N.B.; Sr. Mary Patrice, Melville, Sask.; Peter Pauls, Morden, Man.; Capt. Douglas D. Perkins, Camp Borden, Ont.; Arthur W. Read, Sarnia, Ont.; John R. Robson, Kingston, Ont.; Sr. Rose Marie, Blind River, Ont.; Sr. Rose-Thérèse, Castor, Alta.; Sr. St. Jean de la Croix, Seven Islands, P.Q.; Walter N. Saranchuk, Elk Point, Alta.; Dr. John N. R. Scatliff, Winnipeg, Man.; Hugh H. Sim, Winnipeg, Man.; Selwyn B. G. Simons, Kimberley, B.C.; Victor F. Simpson, Montreal, P.Q.; George C. Smith, Kingston, Ont.; Jess W. Smith, Edmonton, Alta.; J. Douglas Snedden, Toronto, Ont.; Sr. M. Stanislaus, Charlottetown, P.E.I.; John E. Stevens, North Surrey, B.C.; Marvin D. Tice, Canton, Illinois, U.S.A.; F/L Norman E. Tompkins, Ottawa; Frederick C. Westwick, Montreal, P.Q.; and Harald Wiskemann, Kitimat, B.C.

(concluded on page 80)

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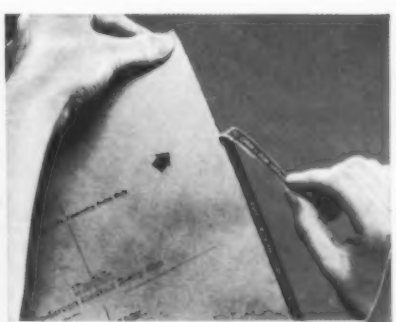

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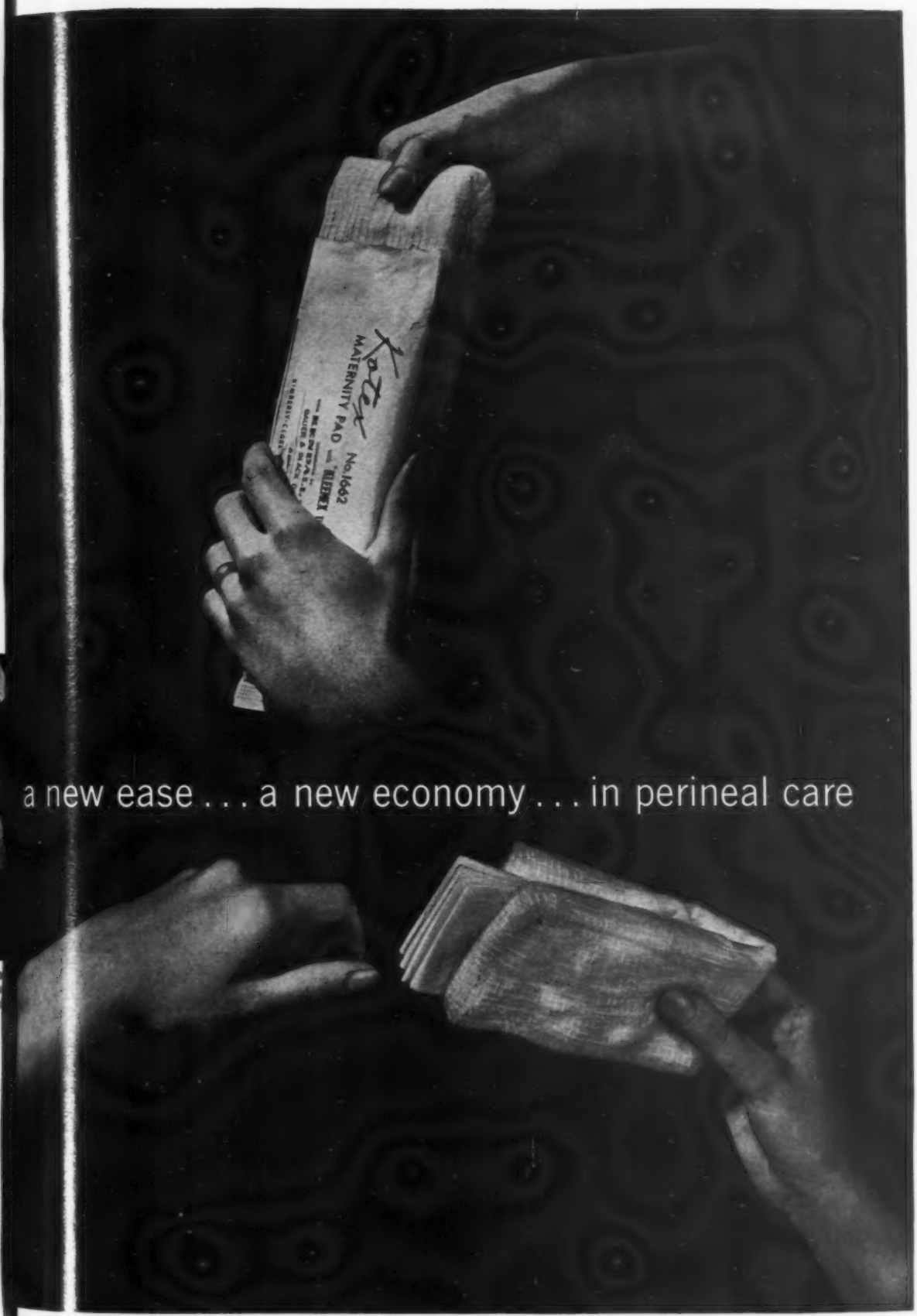
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H.O.M. Students
(concluded from page 76)

First Year Students

The students who attended the first year H.O.M. summer session at the University of Manitoba were as follows: Floyd N. Abrams, Cobourg, Ont.; Robert G. Aman, Calgary, Alta.; Clive F. Applin-Flouch, Kelowna, B.C.; René Auger, Montreal, P.Q.; William F. Blake, Brockville, Ont.; George T. Blencowe, Yellowknife, N.W.T.; William Bush, Toronto, Ont.; Ralph W. Carew, Kingston, Ont.; Ernest G. Casassa, Visalia, California, U.S.A.; Sr. Laura Chalut, Vegreville, Alta.; George J. Cooper, Ottawa; Beatrice Davis, Kenora, Ont.; Verona L. Day, Viking, Alta.; Lucien Desbiens, Montreal, P.Q.; F/L Charles N. Evoy, St. Hubert, P.Q.; Elizabeth M. Forbes, Calgary, Alta.; Michael E. Forestell, Lethbridge, Alta.; Henry P. Friesen, Willowdale, Ont.; Capt. Leslie A. Fuller, Winnipeg, Man.; Dr. George A. Gibson, Courtenay, B.C.; Delbert C. Hamilton, Regina, Sask.; Walter O. Hardacre, Toronto, Ont.; Henry E. Heaton, Swift Current, Sask.; Victor L. Heidgerken, North Battleford, Sask.; Mrs. Marian Hemsworth, Glace Bay, N.S.; Gordon W. Holland, Winnipeg, Man.; Clement J. Hudon, Montreal, P.Q.; Arthur G. Hyndman, Ottawa; Douglas S. Johnson, Newcastle, N.B.; Leslie J. H. Johnson, Sioux Lookout, Ont.; William A. Kertland, Shawinigan Falls, P.Q.; Sidney B. Labovich, Winnipeg, Man.; Paul Lafleur, Gatineau, P.Q.; Sr. Anna Laforge, Bonnyville, Alta.; Sr. Marie Laurent, St. Boniface, Man.; Jean MacLachlan, Montreal, P.Q.; Sr. Mariella, Cranbrook, B.C.; Keith C. Mark, Port Hope, Ont.; George M. Martin, Brantford, Ont.; Sr. Mary of Calvary, Antigonish, N.S.; Nick M. Mayner, Unity, Sask.; Franklin McCorkell, Ottawa; Henry Mueller, Steinbach, Man.; Lorne B. Murray, Toronto, Ont.; Dr. William E. Noonan, Toronto, Ont.; William L. Novasedlik, Windsor, Ont.; Vernon R. Olive, Fredericton, N.B.; Capt. Robert G. Park, Kingston, Ont.; Ian Peddie, Ladysmith, B.C.; Dr. John M. Phin, Hamilton, Ont.; Dr. Archibald C. Pickles, Regina, Sask.; John C. Rivest, Edmonton, Alta.; James L. Roberts, New Liskeard, Ont.; Sr. St. Maurice, Esterhazy, Sask.; Richard A. Schneider, Saskatoon, Sask.; F/O John Scholes, Trenton, Ont.; Glenn G. Smiley, Edmonton, Alta.; Mrs. Audrey Somerville, Espanola, Ont., Robert C. Stagg, Toronto, Ont.; H. Emerson Stewart, Halifax, N.S.; Dan Taylor, Chatham, Ont.; Gilbert G. Todd, Winnipeg, Man.; Philip H. Turner, Kingston, Ont.; Sr. Flore Jeanne Verrier, Tisdale, Sask.; George P. Bolen, Moose Jaw, Sask.; Glen A. Campbell, Toronto, Ont.; and Sr. Margaret H. Guest, Edson, Alta.

Smaller Hospitals
(concluded from page 54)

ous knowledge or experience have to be taken and trained. No small chore today. By the time they are able to take some responsibility they are off to a larger institution and others are benefiting from what you have toiled to give; and you are still training someone just out of school. How many of the smaller hospitals have been able to procure experienced housekeepers and registered dietitians?

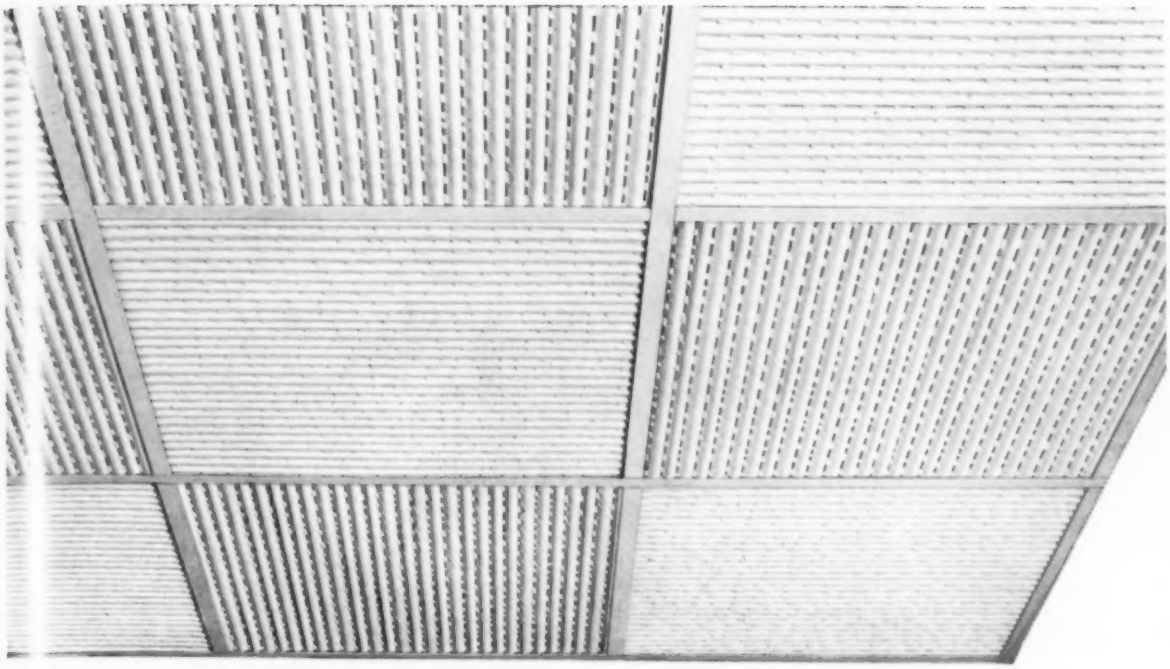
Administration

As already stated, in the larger institution each department is in charge of trained personnel. Rarely does the administrator have to interfere with the work in those areas. In a small hospital the superintendent is housekeeper, storekeeper, purchasing agent, drug clerk and policeman. And in her *spare* time she may have to work in the linen room, laundry, dietary and admitting office. This, along with trying to tell some high pressure sales representative that she is not interested in, or cannot afford, some gadget he insists is so necessary, about covers the day of the superintendent of a small hospital.

Now, if I have not succeeded in convincing you that small hospitals have big problems, it is due to my failure as a scribe not to a lack of problems. ■

New I.O.D.E. Children's Hospital

The half-century old I.O.D.E. hospital and Preventorium on Eldrake Boulevard, Toronto, Ont., which was closed last year, will shortly be demolished and work will commence on the first stages of the construction of a new children's hospital. The hospital will contain 200 beds and preliminary estimates show that the hospital could cost upwards of $3,000,000



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Integrated Hospital Plans
(concluded from page 49)

have been carried out mainly in areas where a high degree of prepayment coverage has been achieved.

Areas in which hospital plans are in operation must decide upon the criteria which they are going to use in established levels of hospital care. Once these criteria have been decided upon, the authorities should then determine the requirements of the area, in accordance with the criteria, and determine how to meet them. In the more densely populated areas, the volume of hospital service at the various levels may be sufficiently large to warrant the establishment of separate hospitals at the various levels (acute, chronic, et cetera). However, this may not be possible in outlying districts, where the volume of service is much less. In this latter situation, a decision will have to be made as to whether or not the patient will be moved to a regional hospital providing the type of care required, or whether some degree of overlapping of the various levels will prevail in certain institutions.

Theoretically, it should be possible to determine the health needs of an area at a specific time. However, medicine is not static, and what appears to be the last word in treatment of a disease to-day could well be obsolete because of a new discovery to-morrow. This is fortunate from the point of view of the people, but it makes it very difficult for the individual or organization attempting to assess the hospital requirements of an area. Usually, it is neither practical nor economical to support all specialized services in all hospitals throughout an area, although a very high standard can be achieved by the process of referral of work and patients. Surveys conducted in rural areas, while attempting to determine the same needs for these people as those in metropolitan areas, must take into account the ability of the area to support the services, and usually recommend some sort of compromise between the two. A higher degree of integration is possible in metropolitan areas, where there are several hospitals within a short distance, as compared with the rural area where there are long distances between each institution.

Typical Survey

Possibly a review of the major areas covered in a typical survey would serve to illustrate how final results are achieved:

(a) A detailed study is made of the geography of the area under review, taking into consideration any natural land barriers, trade routes, et cetera. Existing hospitals are reviewed, and patient loads are studied.

(b) Population trends are analysed, both by age group and sex. The study is broken down into suitable geographical areas, in order to determine if there are any concentrations of certain groups in any district.

(c) The bio-medical statistics of the hospitals provide a great deal of information about the type of patients and the resulting requirements by specialty. Analysis of admissions by clinical services, volume of x-rays, number of laboratory procedures carried out, and the number of major and minor operations all provide an indication of the type of hospital care being provided. Comparison of these indices to trends elsewhere, along with estimates of trends in medical care patterns, should give an indication of any deviation from national or international patterns.

(d) Socio-economic statistics, taking into account the future development of the area, the effect of industrial development as reflected in increasing demand for services, will all affect demands for hospitalization.

(e) Finally, what other health activities and services are available?

A very important factor in determining future projects is a careful analysis of the programs and proposals of groups connected with the hospital field.

The conclusions and observations are finally arrived at, establishing bed ratios, with a resulting number of beds for the area, which may, in turn, be broken down into the various specialties, depending entirely on the original objective of the survey.

If we are to achieve a well co-ordinated and integrated hospital system in any area, in order to utilize our hospital dollars most efficiently and avoid costly duplication and overlapping of facilities, it appears that some form of co-ordination and integration will be necessary. Whether this will take the form of a hospital committee at the local level, or will be some other group, may vary in each case. The changes that have come about in recent years in the hospital field have made it necessary to re-organize somewhat the lines of authority and responsibility for this service. The shifting interest in hospital affairs, from individuals and small local groups to the community and now to senior governments, necessitates the implementation of administrative tools such as surveys, to keep up with these changes. Integrated hospital plans, while starting out as idealistic, should become realistic if we will but turn our minds and resources to the problem. ■

Improved Diet for the Eskimos

With the settling of the white man in the north, new foods for the Eskimos have appeared. One fresh vegetable that is available all the time is the bean sprout—both the little mung bean and the larger soy bean sprout. These are highly practical vegetables for the north for they are shipped and stored dry and they require no special equipment or skill to produce the delicious crisp sprouts. Soy beans can be used as a basis for a concentrated and appetizing trail food which could be eaten cold or quickly heated in a skillet over a small fire. The Eskimo usually uses white flour and water to bake bannock, a typical Eskimo bread. But whole wheat flour and plenty of powdered skimmed milk makes a much better flavoured bread, biscuits and muffins and this change alone could greatly improve the diet of many Eskimos. Another recipe perfected by a white family was a breakfast muffin which contained the same amounts of rolled oats, powdered skimmed milk, powdered eggs, whole wheat flour and dried fruit, which would have been used in a breakfast of porridge with fruit and milk, omelet and whole wheat bread toast. With a glass of fruit juice the muffins made a delicious and complete meal, required only ten minutes preparation time and ten minutes to clean up afterwards. The family also introduced some Oriental foods, and northern adaptations of Oriental foods. A nutritionist working with Eskimos could get many valuable ideas from Chinese methods of preserving and cooking, and use some of the Oriental foods, especially many of the dried foods which can be shipped and stored so cheaply.—*From an article by a public nurse in Canadian Nutrition Notes.*

Public Relations
(continued from page 51)

that they can answer intelligently questions concerning rates, manner of settling accounts and time payment plans. Ideally, admitting personnel should know the community as well as the hospital.

In dealing with the public one clerk who speaks curtly or tactlessly, can cripple any effort to establish good relations. Clerks should be taught to speak slowly, to enunciate clearly in a well modulated tone of voice. They should be taught what to say and how and when to say it. Small courtesies should never be forgotten—please, thank you, would you mind?, I'm sorry, but - - - - -. Very little extra time is needed to give the patient a feeling of recognition and assurance. The clerk's smile should be in evidence always and she should mean her smile by having it shine through from the inside and not be hypocritical about it. Nowhere in the whole hospital does so much hinge on having the right person for the right job, for the admitting clerk is the first good-will ambassador for the hospital.

The telephone switchboard is a critical point of contact between the admitting officer and the public. Here, as at the admitting desk, she represents the hospital to the community and what she says has a significant effect on public relations and the attitudes of patients. What the voice conveys is extremely important — on the telephone the "smile" in your voice is the only indication the caller has of your pleasant disposition. An impertinent or sarcastic tone of voice can build up resentment and ill-will while a kindly, gracious voice can build up numberless friends for the hospital.

Probably one difficulty of the admitting office of the smaller hospital, pertaining to public relations that is sometimes overlooked, is its very smallness. Professional callers, out-patients, patients' relatives and friends who await the visiting hour, are all in view of the admitting or information centre. Hence the receptionist or the admission clerk is under constant scrutiny and must be mindful always that she can not give vent to natural feelings of resentment, impatience or irritability. She must develop a constant courtesy, a mild-mannered disposition and a sincere desire to help others. This latter may reflect itself in the little courtesies of offering to call a taxi or a relative for a visitor or patient, in tying the open shoelace of the aged visitor who finds it difficult to stoop, cautioning the young mother to cover her child well if she is taking it out after a siege of pneumonia or an operation, buttoning the old man's overcoat on a cold windy day because his fingers are bent with arthritis, offering to take a aged visitor on the elevator, taking time out to explain to the young boy what a "fracture" is and the possible attractions of a cast that will prevent him from catching in tomorrow's ball game. Although these things are trivial, they give the personal, homely touch that takes the crispness out of efficiency and gives a sense of dignity and worth to the patient who is an individual and not just another number or case. These are some of the people who make up the public and it is important that hospital contacts leave a pleasant memory. A cheery word and a pleasant smile can make the hospital a better place to live in. Patients and their friends favourably impressed contribute a very definite part to the over-all public relations of the hospital; with that yen for exchange of news the good travels far, but unfortunately, so does the ill, and the latter is more readily believed than the former. Goodwill cannot be purchased; it must be earned.

As long as there is space available for all types of accommodation, there are no problems with the medical staff and good relations prevail. The admitting clerk must realize that temperaments differ. Each doctor wants to see his patients admitted regardless of previous concurrence with established admitting policies; and the doctor who has earlier worked in a small hospital, as the only doctor, is going to be very demanding and sometimes abusively so. Others will find it hard to understand why a particular patient cannot be admitted, despite knowledge of clear-cut admission policies.

The admitting clerk can perform many services for the doctor that spell improved relationships — accepting messages; making valid excuses for him to patients who call to inquire if the doctor has booked a bed, when he hasn't; reminding him of the patient whom he promised to see at a specified time and has forgotten. All of these small services apparently go unnoticed but they do add up to cordial, pleasant relations.

Fitting patients into the various departments or rooms that the admitting officer feels they should have, can create a bit of tension in inter-departmental relations, for this may mean transferral of patients with the resultant multiplicity of work involved; extra work for the nurse-aides, the laundry, ward-clerk and the head-nurse. Segregation of patients according to type of service is not always possible in the smaller hospital, but conferring with the head nurse and getting her suggestion to the best possible arrangement with least upset of routine will usually pave the way to having a transferral done with very little confusion. At times the nursing unit will request the transfer and the admitting officer will accede graciously if it can be done. Special mention should be made of relationships with the operating room staff. The admitting clerk should always consult with the surgical supervisor before booking in a patient for surgery. Tense spots are thus avoided and everyone, doctor, patient, nurse and admitting clerk is happy.

Thus through courtesy and co-operation in dealing with personnel in the nursing departments, as well as the x-ray, kitchen, laboratory, physiotherapy, and business office, the admitting clerk can add significantly to the public relations score. Good team-work will prevail, resulting in better patient care. At times requests will be importunate; at times the admitting clerk will feel that she is being imposed on; but always she is grateful for the opportunity to help, thus strengthening a link in the public relations chain.

A recommendation for good public relations on the part of the admitting clerk is that she take it upon herself to cultivate these qualities that will make her a good public relations medium, loved by her fellow-employees, respected by the patients and their friends, and esteemed by the medical staff, for "the greatest values on earth are not science, not even scientific medicine. They are human values. The human heart, the human spirit. This is our philosophy of operating small town hospitals. It is at the heart of a successful public relations program. Patients are people and only people are worthwhile.'" If good human relations are practised within the admitting office then there will be no reason to worry about good public relations which, for the smaller hospital, lies in providing

(concluded on page 88)

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A.C.H.A.

(concluded from page 62)

E. L. Casey, controller, Winnipeg General Hospital, Winnipeg, Man.

Sr. Germaine-de-Marie, assistant superintendent, Ottawa General Hospital, Ottawa.

G. W. Hollingshead, business administrator, Charles Camsell Hospital, Edmonton, Alta.

Frank W. Hunnisett, personnel director, The Hospital for Sick Children, Toronto, Ont.

Christina Louise Keehn, assistant administrator, The General Hospital of Port Arthur, Port Arthur, Ont.

Charles F. Lavery, administrator, Kelowna General Hospital, Kelowna, B.C.

Sr. Marie-des-Neiges, administrator, l'Hôtel-Dieu de Gaspé, Gaspé, Que.

Sr. Marthe-du-Sauveur, superintendent, St. Vincent Hospital, Ottawa, Ont.

Sr. Mary, administrator, St. Joseph's Hospital, Barrhead, Alta.

Sr. Mary Consolata, administrator, St. Michael's General Hospital, Lethbridge, Alta.

Paul E. Olivier, administrator, l'Hôpital Jean Talon, Montreal, Que.

Lillian Helen Parsons, administrator, Oakville-Trafalgar Memorial Hospital, Oakville, Ont.

S. V. Pryce, administrator, Alberta Children's Hospital, Calgary, Alta.

Sr. Sainte-Laure, assistant administrator, l'Hôpital Ste-Thérèse, Shawinigan, Que.

Sr. St. M. Magdalen, superior, Hotel Dieu Hospital, Cornwall, Ont.

Mother St-Ambroise, superior and administrator, l'Hôtel Dieu Notre-Dame de l'Assomption, Joliquiere, Que.

Horace V. Snyder, administrator, Sudbury Memorial Hospital, Sudbury, Ont.

Sr. Thérèse Trottier, administrator, l'Hôtel-Dieu de Saint-Jérôme, Saint-Jérôme, Que.

Ken R. Weaver, assistant director, The Vancouver General Hospital, Vancouver, B.C.

Kenneth J. Williams, M.D., associate superintendent, Royal Alexandra Hospital, Edmonton, Alta.

John C. Wong, M.D., administrator, The Doctors Hospital, Toronto, Ont. ■

Public Relations

(concluded from page 86)

modern, scientific health care, plus compassion, sympathy and understanding—in thinking of the patient as a person.

References

1. Manual of Admitting Practices & Procedures, p. 1, published by the American Hospital Association.

2. Malm, Harry M. & Pannkoke O. H.: A Hospital's People are its Richest Resources, *Hospitals*, July 1, 1959, p. 46.

3. Ibid p. 47. ■

Muskoka Sanitarium Converted to Hospital School

The Muskoka Sanitarium in Gravenhurst, Ont., Canada's oldest tuberculosis hospital, will be converted to a hospital school for care of mentally retarded children. About three hundred children from the Ontario Hospital at Orillia will be moved to the sanitarium to help relieve overcrowding there and enable erection of a new wing at the Orillia institution.

The sanitarium was operated by the National Sanitarium Association since the foundation of the hospital in 1896 by Sir William Gage and a group of Toronto men. Lately the sanitarium has only been partly occupied because of the decline in the incidence of tuberculosis in Ontario.

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People

(continued from page 30)

New Brunswick Doctor Honoured

Dr. Arnold Branch, chief of laboratory service, Lancaster Hospital, D.V.A., Saint John, N.B., received notification from the World Health Organization of his appointment to the W.H.O. Expert Advisory Panel on Antibiotics, for a period of five years. Membership on a panel is an honorary appointment and the members are asked to give the Organization information on important developments in their own subjects. Dr. Branch is also medical director of the Red Cross blood transfusion service for New Brunswick.

Orthopaedics Chief Appointed

Dr. F. R. Tucker, chief of orthopaedic surgery in the faculty of medicine, University of Manitoba, has been named chief of the department of orthopaedics at the Children's Hospital in Winnipeg, Man. Dr. Tucker graduated from the University of Manitoba, served with the Royal Canadian Army Medical Corps, took post-graduate work in England and has practised orthopaedic surgery since 1949. Recently he has been in charge of teaching and research at Winnipeg General Hospital.

Radiologist Appointed

Dr. D. C. R. Burrows has been appointed radiologist for the new Joseph Brant Memorial Hospital at Burlington, Ont., which will open early in 1961. Dr. Burrows is a graduate of Bristol University, England, and a member of the Royal College of Physicians and Surgeons, Ireland.

Memorial Bursary

The Outpost Hospital Committee of the Ontario Division, Canadian Red Cross Society, has announced the establishment of a bursary in the memory of the late Ida B. Brand. It will be granted annually to a nurse on the staff of one of the Red Cross outpost hospitals to assist her to further her education at a university.

Miss Brand had been director of the Ontario Outpost Department since 1947. For many years she was active in the Registered Nurses' Association of Ontario.

New Appointment At the Winnipeg Children's

Nancy Franklin has taken the position of Director of Nursing at the Winnipeg Children's Hospital, Winnipeg, Man. Mrs. Franklin was formerly with the Montreal Children's Hospital where she spent 12 years. Mrs. Franklin received her early training at Great Ormond Street Hospital in London, England, took three years of paediatric nursing, followed by two years of general training and midwifery, and a six-month university diploma course in Montreal.

- Miss Marilyn Harris of Halifax, N.S., and former treasurer of the Canadian Society of Hospital Pharmacists, has moved to Ontario and has taken the position as chief pharmacist at the Chatham Public General Hospital, Chatham, Ont.
- Jean Paul Montigny of LaSalle, Que., has been chosen as assistant administrator for the LaSalle General Hospital in Montreal, Que., which is at the present time under construction. Mr. Montigny has been in the employ of the Arbour company for a number of years.
- Dr. Raymond Labrecque has been named medical director of l'Hôpital Ste-Justine, Montreal, Que., succeeding the late Dr. Edmond Dubé.

(concluded on page 94)

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People

(concluded from page 92)

• J. D. Wilson, former accountant has taken over the newly established position of office manager at the Toronto Western Hospital, Toronto, Ont. Succeeding Mr. Wilson as accountant is P. S. Fraser, C.A., formerly with Gunn, Roberts and Company.

• H. L. Livergant, co-ordinator of the Northwest Regional Hospital Council of Saskatchewan has announced the appointment of two new members to the staff. They are Miss E. Cole, nursing consultant and Miss G. L. Carlson, dietary consultant.

• Alwyn Mullin, B.H.Sc., has been appointed to the staff of the Ontario Hospital Association as assistant secretary—dietetic services.

• Annelies Ritter has been appointed director of group guidance at The Montreal Children's Hospital, Montreal, Que. She replaces Mrs. R. Emans who retired recently. Miss Ritter was formerly director of the children's recreation department of the Babies' Hospital Unit of the United Hospitals of Newark, New Jersey.

Research in Rehabilitation

Research is of paramount importance on three fronts:

(a) To analyze and demonstrate the working capacity of disabled persons for the purpose of providing widespread and sustained publicity of a factual kind with special reference to the work performance, accident rate and stability in employment.

(b) Research into the work physiology, psychology and emotional patterns of the handicapped is important, and experimental programs are being conducted in several countries. The activities of the work clinic of the Karolinska Hospital in Stockholm, Sweden, may be mentioned in this connection as a pilot scheme. It seems that Canada should keep abreast of these advances both by adapting foreign findings to her particular labour market and by promoting a program of her own in association with physiologists and psychologists.

(c) Time-study engineers, production specialists and personnel managers together with safety engineers and industrial staff can collaborate, combining to prove that industrial equipment and methods can be adapted, sometimes with ingenious devices.

In conclusion, we would like to mention the statement of the famous British novelist John Galsworthy, often quoted by Dr. Frank H. Krusen of the Mayo Clinic: "Restoration is at least as much a matter of spirit, as of body, and must have as its central truth: that body and spirit are inextricably joined. To heal the one without the other is impossible . . . Therefore, I would say: . . . 'Give him interest in his future. Light a star for him to fix his eyes on . . .'. A niche of usefulness and self-respect exists for every man however handicapped; but that niche must be found for him. To carry the process of restoration to a point short of this is to leave the cathedral without a spire. To restore him, and with him the future of our countries, that is the sacred work."—*From an article by G. Gingras, M.D., and J. Gagnon, M.A., in The Canadian Medical Association Journal*

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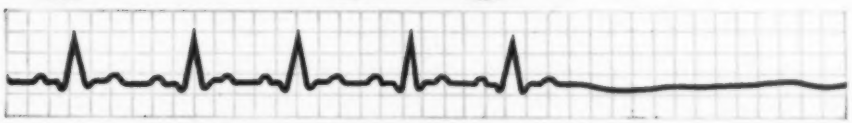

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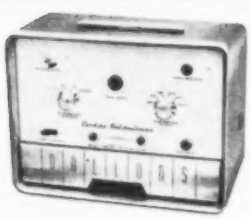

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Now or Never

(concluded from page 36)

vances and discoveries may well be punished by a resurgence of the disease.

There seems to be general agreement among medical historians that the tuberculosis death rate, and probably the incidence also, began to decline before Koch isolated the bacillus (1882), the event which launched a campaign then to banish the disease . . .

Communicable diseases go in cycles if left to themselves and they die out only when and if mankind is able to exert some artificial block—such as pasteurization of milk, immunization, or mosquito control. Our generation has been incredibly lucky to have the tools made available when they can be most effective. Diagnosis is practical, facilities can be adequate, and for the past 15 years we have had drugs which arrest the disease. There are, however, voices warning that drug-resistant strains of the tubercle bacillus are emerging and that there is a time limit on the maximum effectiveness of such drugs.

Returning to Dr. Dubos—he claims that every possible tool must be used now while the general health of the nation is good and before there is danger of resurgence. In 20 years it will be too late. A news item in the same *Bulletin* indicates that Canada still has more than 7,000 new cases annually, with half as many reactivations. Any day of the year 10,000 patients and their families in this country are suffering social and economic hardship caused by protracted illness with tuberculosis.

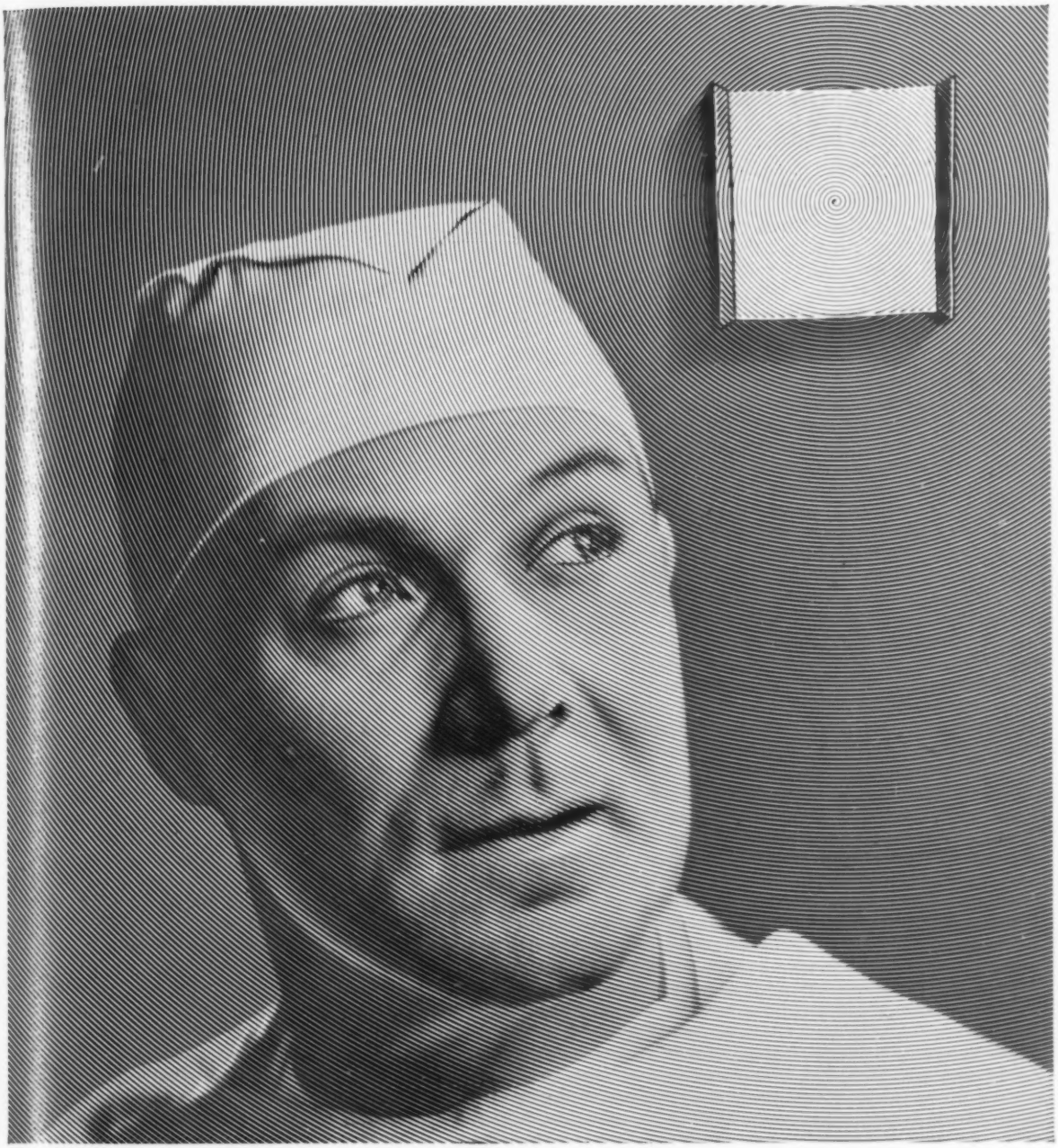
It is true that a few sanatoria have been closed and that tuberculosis is no longer the "great white plague" but it is definitely still with us; and every Canadian should take note of Dr. Dubos' urgent warning.—*J.F.* ■

Purchasing Agents Section Organized

During March of this year a nucleus group of hospital purchasing agents met with Stanley Martin, executive secretary treasurer of the Ontario Hospital Association to discuss the formation of a purchasing agents section of the association. A committee of three, composed of George E. Miller, purchasing agent, National Sanitarium Association, Toronto, George A. Ross, purchasing agent, Princess Margaret Hospital, Toronto, and Ivor H. Hunt, purchasing agent, Toronto East General and Orthopaedic Hospital, Toronto, was appointed to act as a liaison between the group and the Ontario Hospital Association to co-ordinate the details for the formation of the new section and to plan a program for the October convention. With the assistance and guidance of officers of the Ontario Hospital Association, plans have been completed for a well organized section program. It is anticipated that the section will have a substantial number of members registered prior to the convention meeting.

To reform is a frustrating task; to be reformed is maddening.

—*English Digest*



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Here and There

Southwell Hospital in Kuwait

A 250-bed hospital, designed to take a further 80 beds if necessary, has been opened at Ahmadi, Kuwait, on the shores of the Arabian Gulf. It has two main operating theatre suites, one emergency operating theatre suite, a small fracture operating theatre, an eye theatre and two delivery suites. The hospital was provided by the Kuwait Oil Company. An important feature of the hospital is the air-conditioning plant with ten main and several subsidiary installations. Outside temperatures sometimes reach 120 deg. F. and humidities up to 70 per cent R.H. Extraction of sand from the atmosphere is a big part of the problem since sandstorms are so penetrating that they can even percolate into a factory-stoppered jar of jam.—*Hospital and Health Management*

New School in Dentistry

A new training school is to be opened in the grounds of New Cross General Hospital, London, England, where young women from all parts of the United Kingdom will be trained to work as dental auxiliaries helping dentists in the provision of dental treatment for children. At the end of a two-year course, which will be provided free, they will be able to take up employment in the local authority health services where they will work under the direction of dental surgeons who will examine the patients and prescribe treatment to be given. The training school is designed to take 60 students each year and the first course will begin in October of this year.

Visiting Nursing Services in Denmark

Hospital facilities in Denmark (exclusive of mental hospitals) provide 5 beds per 1,000 population. Health matters and general hospitals are regarded as local responsibilities, but subsidies are provided by the central government. A survey carried out a few years ago indicated a need for additional facilities for long-term care, in order to release beds required for the care of acute illness. As a result financial assistance has been made available to nursing homes.

Under a law passed in 1957, every community is now required to establish a visiting nursing service, and the central government is in the course of drawing up regu t- tions and organizing consult t services in this regard. The ba is for the new plan is the visit g nursing service organized in Cop n- hagen following the war. Un er this program, aimed at conserv g hospital beds, home nursing r- vices are available to anyone, e- gardless of income. An evaluat on is made of each case before adn s- sion to hospital, and, where ad s- able, the home nursing service r y be called on in the continuatio of treatment after discharge f m hospital. The Copenhagen plan as been found to be very satisfact y. The system is now being exten ed whereby, on the advice of the t- tending physician, homemaker r- vices may be provided.— *Canad n Nutrition Notes.*

In Nigeria

The nation-wide leprosy c m- paign has brought hope to th u- sands in Nigeria—there are ow over 1000 treatment cent es throughout the country, and m re than 200,000 under treatment.

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Thomas Carlyle

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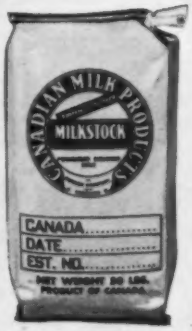

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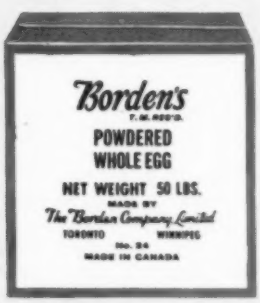

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Coming Conventions

Sept. 20-21—Catholic Hospital Conference of Alberta, 17th annual meeting, Jubilee Auditorium, Edmonton, Alta.

Sept. 26-30—College of American Pathologists and the American Society of Clinical Pathologists, 14th and 39th meetings respectively, Palmer House, Chicago, Ill.

Oct. 10 - 11 — Catholic Hospital Conference of Saskatchewan, Bessborough Hotel, Saskatoon, Sask.

Oct. 10-14—American College of Surgeons, 46th Annual Clinical Congress, San Francisco, Calif.

Oct. 12-14—Saskatchewan Hospital Association, annual meeting and convention, The Bessborough Hotel, Saskatoon, Sask.

Oct. 18-20—Manitoba Hospital and Nursing Conference, Winnipeg.

Oct. 24-26—Ontario Hospital Association, annual convention, Royal York Hotel, Toronto, Ont.

Oct. 25-27—Associated Hospitals of Alberta, Northern Alberta Jubilee Auditorium, Edmonton, Alta.

Oct. 27-28—Ontario Conference, Catholic Hospital Association, St. Joseph's Hospital, Toronto, Ont.

Hospital Financing

(concluded from page 53)

quite normal, the doctor's batting average for recoveries was probably excellent. Therefore, results alone cannot be the sole criterion of efficiency.

The answer may well be a combination of criteria—results, yes—but also adequacy of staff, qualifications of staff, proper organization of medical staff and department personnel, good administrative leadership, breadth and scope of the services offered to the public, satisfactory medical audit, and a budget and cost accounting analysis that compares favourably with other hospitals *in the light of the services provided*. To these should be added the priceless ingredients of tender care and staff morale. These factors could never be reduced to a simple formula, although a system of point allocation should have much promise and would let a hospital try each year to top its record of previous years.

No, we have not departed from our theme of hospital financing, for many of these requirements can only be achieved with adequate payroll, trained personnel and good equipment.

Effect of Hospital Insurance

We are all quite familiar with the economic advantages of prepaid hospital coverage, be it through a Blue Cross or other non-government plan, or through a government-sponsored program. But one very important aspect of this method of financing hospital care has received little comment. That is the relief to the patient from worry over financing his hospital care.

In many instances where the patient doesn't know how he can possibly meet his hospital bill on top of all his other expenses, the worry and anxiety prevents him from sleeping, keep him constantly under tension and can definitely delay his recovery. Or it can lead the patient to leave hospital too soon with resultant delayed convalescence or possible relapse and readmission. This peace of mind, an essential element in psychotherapy, is a very important factor in the treatment of patients.

Another effect which we can see already is that a hospital under the present insurance plan has its essential operating expenditure covered by the Commission payments. In addition, it has certain designated sources of revenue (a portion of private patients' revenue, the special bed grant and, where applicable, Sisters' salaries). With the essential expenditures covered, hospitals can use for special purposes such other income as they may receive from various sources more freely than would have been the case previously.

Here I have dealt with various evidences that adequate financing has a definite relationship to the quality of patient care, be it in the physical plant, equipment, or the quality and number of personnel. At the same time, other vital factors—the morale and attitude of the whole organization—are just as essential to good patient care.

In parts of Africa, water is so precious that it is stored underground, buried in ostrich eggs — *World Health*

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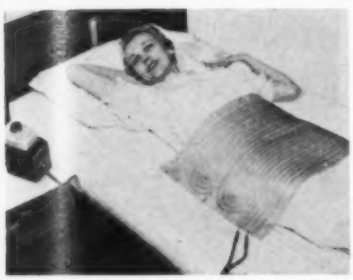

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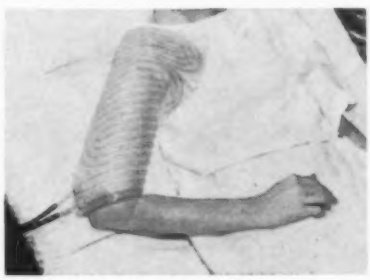

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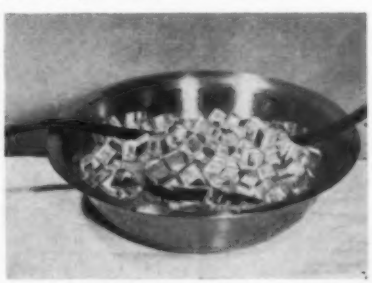

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Hospital Accreditation
(concluded from page 56)

ciated with hospital work, to raise the question: Is my hospital accredited and, if not, why not? It may be that the hospital is not eligible; accreditation to date has not been made available to hospitals under 25 beds or hospitals which have been open less than one year. Among the hospitals that are eligible, I do not believe there are many which are unable to meet the basic minimum standards or are not providing good quality patient care or have stopped improving. I believe that the most frequent reason for a hospital not being accredited is the simple one of complacency. We tend to feel that, as long as we are satisfied within the four walls which enclose our hospital, that is all that is necessary. However, I have tried to point out that we are, in fact, providing good-quality care and are striving for continual improvement. It is complacency which must be overcome and it is the responsibility of everyone working within the hospital to be constantly critical of the services and facilities provided, so that we are not only providing good-quality care but are steadily progressing. When we cease improving, it is time we stopped functioning in the hospital field. ■

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Book Reviews
(continued from page 75)

the first four may be adapted for a panel discussion.

Naturally nurse-patient relationships are stressed throughout. The author also aims to give the nurse an insight into the powers of the human mind, to help her know how learning takes place and to strengthen her active participation in the all-round adjustments of the patient. Thus this serves as a very useful textbook for the nurse beginning her training.

* * *

DIABETES MELLITUS, A Handbook for Nurses, by Marguerite M. Martin, R.N. Published by W. B. Saunders Company, April 1960. Illus. Pp. 167. Price $3.50.

The author of this book prefaces her work by saying that she has endeavored to write a handbook for nurses which will be complete in all phases of diabetes and to make the scope of discussion sufficiently broad so that nurses in the various fields of nursing will benefit. Medical data which the nurse needs to know and might be interested to know is included. According to the author, statistics reveal that there are approximately two million diabetics in the United States at the present time. Because of its increasing frequency diabetes is a disease of importance from a social as well as medical standpoint, and the nurse who participates in the care and education of diabetic patients, as the link between the physician and the patient, can help the patient both emotionally and physically with her understanding of the ground rules of diabetes.

Mrs. Martin has taken postgraduate work at the New England Deaconess Hospital in Boston, Massachusetts, which is associated with the internationally known Joslin Clinic.

* * *

LABORATORY MANUAL AND WORKBOOK IN MICROBIOLOGY FOR STUDENTS OF NURSING by Lucille Sommermeyer, R.N., B.S., Ed. M. Published by W. B. Saunders Company, 1960. Pp. 154. Illus. Price $3.50.

This laboratory manual has been prepared in conjunction with the tenth edition of Frobisher and Sommermeyer's *Microbiology for Nurses*. The organization of the manual is as follows: introductory material on the microscope, morphology and staining microorganisms to disinfection and sterilization, sanitation, and immunity and pathogenic microorganisms. This is a common sequence in teaching microbiology in schools of nursing. The section on pathogenic microorganisms has been reorganized and presented from the viewpoint of methods of transmission rather than using morphological characteristics as the primary organizational pattern. For clarity, each laboratory exercise is divided into key steps and important points.

It is the author's belief that laboratory work in microbiology can be taught without exposing the students to highly pathogenic microorganisms and that all cultures of microorganisms should be handled with caution bearing in mind that beginning students in schools of nursing have not developed their aseptic technique sufficiently to warrant the hazard of having them handle virulent cultures.

While this laboratory manual is too long and detailed for some courses in microbiology in schools of nursing, the exercises are written so that if omission is necessary the continuity will not be lost. The author believes that this manual

(concluded on page 110)

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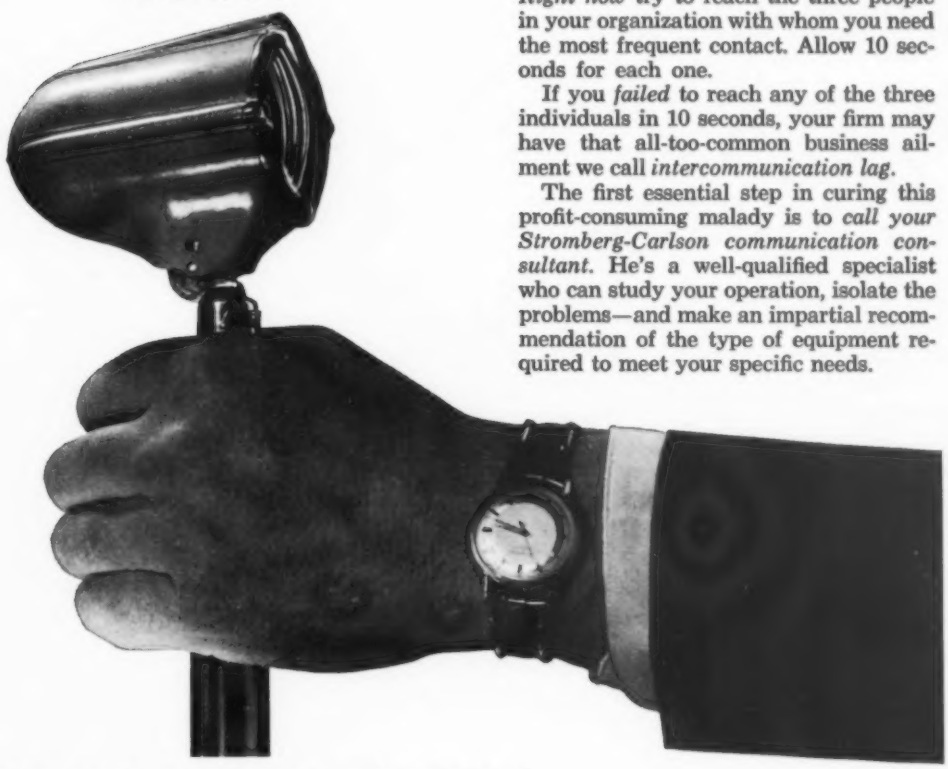

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STROMBERG-CARLSON

A DIVISION OF GENERAL DYNAMICS

Progressive Patient Care
(concluded from page 58)

be required. This, however, has not been finally determined. The category of intermediate care is similar to that provided on the nursing units of our traditional hospitals.

Organization and Control

Good results in a hospital depend upon the co-ordination of the work of many people of diversified interests and talents. While the traditional method of sorting out medical staff assignments (into medico-administrative and clinical) may be sound for conducting certain of the affairs of the medical staff, we think the principle of organizing by process can be carried too far. Within the medical staff organization itself, we believe that broader representation on committees proves advantageous. Then, if key people from the departments staffed by the hospital can be included in some of the meetings of medical staff committees, the first real step toward co-ordination will have taken place. Obviously this could not apply to all medical staff committees. In testing this technique at our hospital, however, we have found the results encouraging.

The administrator must first accept the fact that the practice of medicine dominates all hospital activity and then assign hospital personnel to rôles supporting the medical staff and the work of their committees. This approach greatly increases the probability of an efficient and harmonious hospital. If the administrator can instill into all hospital people a singleness of purpose, the doctors will be encouraged to accept the responsibilities delegated to them.

The practice of medicine in a hospital is indivisible from nursing, dietetics, linen service, medical records, finance, et cetera. It is not possible to consider a problem in one department without involving several other areas. Thus it is important to bring together as often as possible all persons concerned with the policy, management or the operating aspects of a particular matter or problem.

We are of the opinion that progressive patient care encourages the drawing together of doctors and hospital personnel. Under this system policies and regulations are not considered as relating to female surgery or male medicine but rather to a management area where all types of patients with similar medical and nursing needs are accom-

n dated. The consequent bringing together of various interests on an area basis helps to draw hospital groups closer together. The management and control mechanism for a particular zone at Queensway may well follow the study pattern. That is, representatives concerned with the operation of a particular zone form committees. The composition of committees varies according to the service being performed; but they may include, for instance, an internist, surgeon, general practitioner, nurse, dietitian, an anaesthetist, a physiatrist, and the administrator.

An organization based on this concept would appear to reduce the blocks in the administrative process; and the final result may well be the development of better feeling and understanding throughout the entire organization. We have tested the committee technique and the results have been good. Hospital people want to do whatever is right and best for the patient; and the team philosophy applied to the clinical areas of the hospital, as is reasonable under progressive patient care, holds promise of furthering our aims.

So far at Queensway we are preparing the ground upon which to build a new foundation for a better superstructure. A committee of the medical staff, with the assistance of hospital personnel, is attempting to set up a pilot plan within the existing hospital. This should provide information valuable in the planning of an enlarged hospital where we hope to incorporate the progressive patient care concept. ■

General Practice Clinic at Saint John General

At the Saint John General Hospital, Saint John, N.B., the outpatient service is now operated by the department of General Practice. A clinic, staffed by 18 general practitioners, is under the direction of Dr. Stephen D. Clark as chief of the service. The purpose of the general practice clinic is to take care of all indigent patients or emergency patients who do not have their own physician. Previously the department of Medicine looked after indigents. Now the clinic patients are treated by a general practitioner or referred to the various speciality clinics in the outdoor service. Dr. Clark and six other members of the General Practice department are members of the College—*College of General Practice Bulletin*

is comprehensive enough to meet the needs of the most extensive courses in microbiology given in schools of nursing.

* * *

100 TO DINNER, by Elspeth Middleton, Murile Ransom Carter, and Albert Vierin. Published by the University of Toronto Press, Toronto, 1960. Pp. 381. Price $6.95.

100 to Dinner is a recipe manual designed to serve as a cooking guide in institutions, where a large number of people have to be served —clubs, schools, hospitals, tourist resorts, et cetera. The book is compiled as a result of work done by the authors during the second world war. The recipes are set out with great clarity and directions are simple and easy to follow and the recipes are constructed in such a way as to provide attractive, nourishing meals, requiring no elaborate methods of preparation. Quantities for each ingredient are given by both weight and bulk measures. A special table of weights and measures for a great number of foods has been included to obtain more accurate results when using the recipes.

To relieve the repetition of menus that usually occurs when preparing them for a large group, the authors have included many variations of simple recipes as well as many wholly new ones. The book includes recipes for all the courses of a meal and for most of the main categories of foods, such as eggs, meat, vegetables, bread, et cetera. Each section includes a "do and don't" chapter explaining the causes and cures if the food fails to turn out as it is supposed to. A complete section on frozen foods has been included along with suggestions for using other prepared foods developed in recent years.

A number of tables, such as time and temperature charts for baking or roasting, the names and uses of various herbs and spices as well as definitions of the different terms used by a cook have been included. A number of diagrams illustrating the various cuts of meats that can be obtained from certain animals show clearly the type and use of each cut.

The manual can be of help to anyone who is concerned with the preparation of meals for large groups of people and more so to those without long professional experience.

* * *

Report of Congress Proceedings

The Proceedings of the Eleventh International Hospital Congress, *Efficiency Methods in the Hospital*, which was held in Edinburgh, June 1st to 6th, 1959, is now available. It has been published by the International Hospital Federation, 34, King Street, London E.C. 2, and the price is £1 for members of the I.F.H. and £1.5.0 for non-members. All the papers presented are published in full, together with a summary of the discussion at each group meeting.

Wing Opened at St. Mary's Memorial Hospital

The new Arthur Meighen Wing was recently opened at St. Mary's Memorial Hospital, St. Mary's, Ont., by the Hon. J. W. Monteith, Minister of Health and Welfare. About two hundred guests were present at the opening. The new wing, which has 26 beds, brings the total number of beds in the hospital to 62. The wing will be operated as a separate part of the hospital, probably for the benefit of the more seriously ill patients who require more exacting care and treatment.

Northern Health Services

The Northern Health Services (National Health and Welfare) was formed in 1954 and is concerned with public health services for all citizens of the Northwest Territories and Yukon Territory as well as providing treatment services where the pattern of private medical practice has not been established. The Health Services has to work in two directions. In places such as Whitehorse, Fort Smith and Aklavik, it must try to provide the level of service that people who are accustomed to paying their own medical bills expect, and yet at the same time it must endeavour to provide good service to citizens living in other parts of the Territories who are either indigent or are living off the land in the Indian or Eskimo way of life. These people live away from established settlements in comparative isolation and the geographical conditions and the high cost of transportation and communication complicate attempts to provide the services to these groups. In the Yukon Territory these people represent less than 30 per cent of the population but in the Northwest Territories the percentage is over 60 per cent and many of these people can only be reached by air and sometimes not at all.

More difficulties are created by the fact that morbidity and mortality rates, especially infant, for Indians and Eskimos in the Territories are higher than for citizens in other areas. For example, only 11 per cent of all the deaths in Canada in 1955 were of infants under one year of age, 51 per cent of Eskimo deaths from all causes were infants during their first year of life. In 1957, 23 per cent of all Eskimo infants born alive died before they reached the age of one year. The figure for the rest of Canada was only 3 per cent. There is very strong evidence that more than half these infants died from acute infections of the respiratory system. The rate for Indian babies is more than three times the white baby death rate.

The need for public health services—maternal and child care, sanitation, school health services, tuberculosis control, care of workers in various types of cases, and general health education is all the greater because of the lack

From an article by John S. W is in Northern Affairs Bulletin.

of utility services that are taken for granted in most other Canadian communities. When compared with public health agencies in other parts of Canada, Northern Health Services has the task of trying to cope with proportionately more sickness and death, much more widely scattered over more inaccessible country, in generally worse weather, with more limited transportation facilities, poorer communication, and with limited funds.

The Health Services found that one way of dealing with the situation is the use of a self-help program. Perhaps one or two persons in each camp or settlement can be trained to teach the basic principles of hygiene and sanitation and render first aid and home nursing when disease strikes. The Health Service already relies heavily on the "lay dispenser"—policeman, store manager, teacher, priest or clergyman—who is provided with a small stock of simple remedies and administers these on instructions obtained by radio from the nearest doctor. Recently a program has been launched for the training of Indian and Eskimo health workers, young men and women, selected with the advice of the local Indian or Eskimo elders, who can be given instructions in the use of the remedies in a simple medicine chest, together with simple training in first aid and home nursing. An experimental Eskimo medicine chest has already been completed and will be tested this coming winter.

The administration of the Northern Health Services is always faced with the considerable expenditures that are required for every project. It costs upward of $50,000 to construct a northern nursing station, and in the order of $25,000 per annum to maintain either a team of two nurses or a doctor and his family at a northern settlement. The Indian Health Services is already spending annually about $215 per capita for the Indians and Eskimos of the Mackenzie District. And yet, if the north is to be opened up to the point where the average Canadian will be interested in settling, medical services must be provided that will satisfy him and bolster his faith to go.

Sickroom supplies are loaned free by the Canadian Red Cross loan cupboards in 521 communities in Canada. More than 22,000 people have benefitted from this service.

Classified Advertising

Advertisements for insertion should be mailed to Canadian Hospital, 25 Imperial St., Toronto 7, Ontario. Rates for classified advertisements are as follows:

$3.75 per column inch or fraction thereof, minimum charge $3.75. Display advertisements, set in a box, may be requested on advertisements of 2 inches or larger at no additional charge, ¼ page display advertisement — $25.00. Advertisements must be received by the first of the month to appear in that month's issue.

ASSISTANT DIRECTOR

Applications are invited for an Assistant Director of the Extension Course in Nursing Unit Administration. This course is jointly sponsored by the Canadian Nurses' Association and the Canadian Hospital Association.

Qualifications: University preparation in teaching and supervision is necessary with several years experience in a supervisory position. Fluency in the French Language is desirable but not necessary.

For further information write to:

Director, Extension Course in Nursing Unit Administration

Canadian Hospital Association, 25 Imperial Street, Toronto 7, Ontario

Operating Room Supervisor

With post graduate training, required for 180-bed fully accredited hospital. Average monthly surgical load—157. Duties consist of administration of department and educational program of students in department. Basic salary—$335 per month.

Apply stating qualifications and experience to

Superintendent of Nurses,
Victoria Union Hospital,
Prince Albert, Sask.

Nursing Staff Required

EVENING SUPERVISOR:—With experience in ward supervision as a minimum.

ASSISTANT SUPERVISOR:—With experience in supervision required.

O.R. SUPERVISOR:—With post-graduate course or experience in supervision of O.R.

REGISTERED NURSES:—For general staff.

Salary scale of Association of Nurses of the Province of Quebec.

Write to: Director of Nursing, Lachine General Hospital, Lachine, P.Q.

Administrator Required

New construction and renovation currently in progress will provide 145 beds at the Dauphin General Hospital. Candidates for the position of Administrator are invited to forward details of qualifications and training without delay to Mr. E. W. Hawkins, Chairman of the Board, Dauphin General Hospital, Dauphin, Manitoba.

DIRECTOR OF NURSING

Preference will be given to an applicant holding a degree in Nursing supported by practical experience in a general hospital.

A campaign is now being conducted to raise funds to expand this hospital in a suburb of Montreal, Que., from the present 80 beds to 140.

This position offers an opportunity for the exercise of judgment and training in building the nursing service of a modern acute hospital.

Please write to Box No.: 802L, Canadian Hospital, 25 Imperial St., Toronto 7, Ont.

Director of Nursing

required for

New 150-bed General Hospital
(Planning C.N.A. Training School)
Located in Large Resort Area

Apply giving full particulars and salary expected to:

ADMINISTRATOR
ROSS MEMORIAL HOSPITAL
Lindsay, Ontario

DIRECTOR OF VOLUNTEERS

Required
For organization and direction
of
An extensive volunteer programme
in
Large general hospital

Apply: Miss Edith Young,
Assistant Administrator Nursing
Ottawa Civic Hospital,
Ottawa 3, Ontario.

Assistant Director of Nurses Position Now Open

Applicants with training and experience in Nursing Supervision and Administration given preference. Must be capable of assuming position of Director in near future. Interest in staff education and In-Service training program essential. Modern hospital has 110 beds and a Medical Staff of seventeen. Submit written application in first instance with references to H. E. Taylor, Administrator, West Coast General Hospital, Port Alberni, B.C.

Two Staff Dietitians Wanted

For 446-bed hospital with complete program in Victoria. Duties include teaching student nurses, some therapeutic diet work or ward food services; 40-hour week, 10 paid statutory holidays, 4 weeks vacation, medical and pension plan, good salary with 4 annual increments. Write Miss Mary E. O'Brien, Director of Dietetics, Royal Jubilee Hospital, Victoria, B.C.

PHARMACIST REQUIRED

150-bed General Hospital requires the services of a pharmacist to fill a vacancy in a two pharmacist department. For further information regarding salary and perquisites please contact:

Personnel Officer, Brandon General Hospital, Box 280, Brandon, Manitoba.

EDUCATIONAL DIRECTOR

FOR NEW SCHOOL OF NURSING

New school building, new student residence. Hospital opened in 1956, all services 250 beds. Present plan to enrol first class of students for September 1961. Director required at once to facilitate planning an educational program and arranging for staff. Opportunities for additional education at Laurentian University. Salary according to qualifications and experience.

Apply DIRECTOR OF NURSING,

SUDBURY MEMORIAL HOSPITAL
Regent Street South, Sudbury, Ont.

Classified Advertising

Purchasing Agents' Association Formed

This year a Toronto Regional Association of Hospital Purchasing Agents was formed. The executive consists of the following: *president*, George E. Miller, purchasing agent, National Sanitarium Association, Toronto; *vice-president*, Mary Finger, assistant administrator, Women's College Hospital, Toronto; *secretary-treasurer*, Andre Schabracq, purchasing agent, New Mount Sinai Hospital, Toronto; additional members are George D. Lattoss, purchasing agent, Princess Margaret Hospital, Toronto, and Ivor Hunt, purchasing agent, Toronto East General and Orthopaedic Hospital, Toronto.

Hospital at Picture Butte

The new $400,000 hospital at Picture Butte in southern Alberta has received its first patients. Jutting forward from the central portion of the building is the nurses' residence wing. Between the double-storey central building and the single-storey nurses' residence is a large solarium. There are 25 beds in the hospital, including two four-bed wards, eight private rooms and a three-bed children's ward, the remaining beds being in semi-private rooms.

News Released by Hospital Supply Houses

By C.A.E.

T. B. James, Hartz Board Chairman at 92

About 200 staff members of the J. F. Hartz Co. Limited, Toronto, were hosts recently at a surprise party for T. B. James, who is still the working chairman of the board at 92.

"We hope you aren't going to retire" said one of the members of the staff. "I'm not even thinking of retiring" Mr. James assured his well-wishers.

Mr. James uses the same oak desk and chair which he bought when he came with the then U.S. company 60 years ago.

T. B. James

His office is on the main floor where it is convenient to welcome customers and friends when they come in. "I like to be able to see the customers, and they like to see me. My office door is always open," he said.

The editor of "Across The Desk" has been an enthusiastic admirer of Mr. James for the past 36 years, and joins his friends in wishing Mr. James all good fortune and continued good health.

Fisher Expositions of Interest to Scientists

Canadian Scientists will be pleased to learn of a forthcoming series of events of special interest: the Fisher Exposition and Lecture Series on Laboratory Instrumentation, to be held in Toronto, Ottawa, and Montreal later this fall.

According to W. W. Lummis, president of Fisher Scientific Company Limited, which has served Canadian laboratories since 1926, the Exposition in each city will feature an identical two-day program consisting of special exhibits and lectures.

Exhibits include the newest in instruments and apparatus for clinical, research, industrial, testing, and educational laboratories, shown and demonstrated by 35 of the leading producers in Canada, the United States, and Europe.

Hundreds of products will be on display—many of them shown for the first time in Canada—designed to make laboratory work more productive, more economical, more accurate, more convenient — and safer.

Lectures include 11 outstanding talks by Fisher specialists, ranging from fundamentals of spectrophotometry to advanced techniques in gas chromatography and column technology. Included: a colour-slide presentation of "The Fisher Collection of Alchemical and Historical Pictures: A Record of the Evolution of Science from Chinese Alchemy to the Atomic Age".

Exposition dates are as follows: Toronto—Sept. 27 and 28, Sheraton-King Edward. Ottawa—Oct. 12 and 13, The Coliseum. Montrea — Nov. 1 and 2, Queen Elizab th Hotel. Exposition hours: 11 a n. to 10 p.m. daily. There are o admission fees in connection w th any part of the Exposition.

Personnel Change at Ohio Chemical

Effective August 1, 1960, G. Victor Schlitzer assumed the p si-tion of vice president of C io Chemical Canada Limited, 180 D ke Street, Toronto. Hugh D. Came on is president.

ATI Offers Widest Selection of Autoclave Tubing

All autoclave sterilization t b-ing lines of the Northwest rn Converting Company have b en acquired by the Aseptic-Ther mo Indicator Company of North Hollywood, according to a j int announcement made by R. A. Matson of Northwestern and Willard M. Huyck, president of ATI.

Now included in the ATI tubing line is both Kraft wet-strength paper and Patapar tubing. Each style is offered in four different widths, ranging from 1½ to 3 inches, and both the Kraft paper and Patapar tubing are available either imprinted with ATI's Steri-Line indicator for maximum assurance of sterilization, or in a plain white surface without the indicator. All tubings with the S ri-Line imprinting are also pri ed with one-inch markings to ai in cutting the tubing to any des ed length. In addition, space is p o-vided for noting the date of a o-claving and description of he sterilized items.

For prices, informative lit a-ture and a general test supply f tubings, write to The J. F. Ha z Company, Ltd., 34 Grenville Str t, Toronto 5.

(continued on page 118)

Royal Metal Royal-Wood Stacking Chair

Offered for the first time by Royal Metal Manufacturing Company Limited is this new Royal-Wood stacking chair.

The moulded, one-piece seat and back is made of Royal-Wood, a natural wood impregnated and compressed by a new process that makes it lighter than aluminum and almost as hard as metal. Royal-Wood retains its original high gloss throughout its life.

The new material has all the rich beauty of the natural wood grains, yet it is impervious to cigarette burns, ink, tea of coffee stains and mild acids. It is unaffected by sun or rain and can be left outdoors without damage. Under normal use it will not chip or crack.

Illustration shows how the chairs can be conveniently stacked when not in use. Brochure giving full details is available by writing to: Royal Metal Manufacturing Company Limited, Galt, Ontario.

Market Forge Low-Cost Sanitary Shelving

Market Forge Company has published a brochure on Marketier Shelving, a new low-cost, rugged and sanitary shelving for storeroom installation.

In addition to photos of this new and versatile shelving, available in stainless steel or new aluminized steel, the brochure helpfully describes, with illustrations, the many arrangements possible to take full advantage of area space.

Also illustrated and described are the many exclusive features including sanitary smooth shelf surfaces, rounded corners, raised edges, easy installation and practical sizes which are said to eliminate wasted storage space.

This new brochure and further information on Marketier Storeroom Shelving are available from Market Forge Company, Everett 49, Mass.

Sun-X Controls Heat, Fade and Glare

Sun-X tints the glass in a building after it is installed without disrupting the normal routines of the occupants. And Sun-X, applied to your present windows, can give you all the advantages of factory-tinted windows. It's the economical method of sun control. It prevents glare, reduces air conditioning costs, and prevents fading damage from the sun. And it actually improves the appearance of your building.

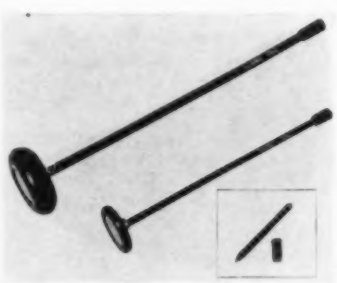
A product of E. I. du Pont de Nemours & Co., Sun-X Glass Tinting has been used throughout the world on hospitals, plants, schools, service stations, and homes.

There are 14 Sun-X colours to meet specific sun control and decorating needs.

Full particulars from Sun-X Glass Tinting Co. of Canada, Limited, Brantford, Ontario.

Reflex Testing With New Percussion Hammers

The Adams Neuroflex Percussion Hammer, recently released by Clay-Adams, Inc., has been very enthusiastically received. This instrument consists of a longer, flexible handle with a donut-shaped pliable rubber head. Because the Neuroflex Percussion Hammer permits a brisker, sharper tap, the physician is assured of a more



sensitive reflex examination. This sharper stroke releases more neurons, producing a more positive reaction. This new style hammer is therefore particularly valuable in testing patients with sluggish or inactive reflexes.

Further details may be obtained by writing directly to Clay-Adams, Inc., 141 East 25th Street, New York 10, N.Y.

New Baxter Physiologic Irrigating Solution

A new physiologic irrigating solution, for use in surgical procedures, has been developed by Baxter Laboratories, Inc.

The solution, available under the name Tis-U-Sol, has been found to offer definite advantages

over certain so-called "physiologic" irrigating solutions such as normal saline, usually employed for irrigation and lavage, Baxter says.

Using tissue culture techniques, recent research has shown that the frequently employed "physiologic" solutions have a damaging effect on living cells. Tis-U-Sol solution is truly physiologic in composition and effect, Baxter says, because it does not cause subtle tissue changes that contribute to complications following surgical intervention or injury.

Tis-U-Sol is a sterile, nonpyrogenic solution with a pH of approximately 6.4. It is composed of special salts in a definite, balanced ratio for support of normal cellular function and tissue survival.

Three New Scotsman Ice Storage Bins Available

Three new ice storage bins for storing flaked and cubed ice are now available from Scotsman,

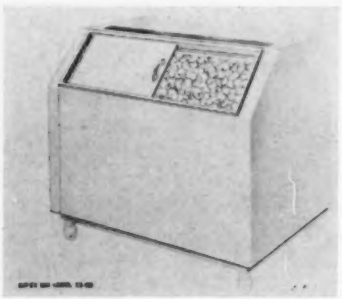
(concluded on page 120)

Across the Desk

(concluded from page 118)

Queen Products Division, King-Seeley Corp., Albert Lea, Minnesota.

The new bins, Series B-400-B, Series BH-1250 and Series SB-1500 have 400 lbs., 1250 lb. and 1500 lb. capacities respectively. The 400 lb. bin fits under a Scotsman Super Cuber SC-500 E. The 1250 lb. model can be used with either one or two SC-500 E's, or an SC-500 E and a continuous-flow Scotsman Super Flaker. The Super Bin model SB-400 is illustrated.



Owners of Super Flakers SF-SE or SF-3F can store up to 1500 lbs. of flaked ice in the vertical, 3-door model. All Scotsman bins are available in a choice of baked-on enamel or stainless steel exteriors, watertight stainless interiors, 3″ fibre glass insulation, chrome-plated brass hardware and multiple doors for easy ice removal.

Scotsman makes over 60 different ice machines with capacities ranging from 50 lbs. of cubes to over two tons of flakes per day.

Demineralizing Catalogue Issued by Barnstead

A new 36-page catalogue features the complete line of Barnstead Mixed-Bed, Two-Bed, and Four-Bed Demineralizers. A special section is devoted to Barnstead "Train" equipment which produces ultra pure water of 18,000,000 ohms resistance at 25°C.

The equipment also removes organics, inorganics, bacteria, gases, and submicroscopic particles down to 0.45 micron. It also describes Barnstead tin-lined piping, fittings and faucets; purity meters, storage tanks, sand and carbon filters; submicron filters, and other auxiliary equipment.

Case histories of Barnstead "Specials" are also described and illustrated. Catalogue No. 160 is profusely illustrated with charts, specification drawings and actual on-job installation photos. Catalogue No. 160 may be obtained by writing Barnstead Still & Sterilizer Co., 171 Lanesville Terrace, Boston 31, Mass.

Catalogue on Hospital Restraints

The Humane Restraint Company of Madison, Wisconsin, has just produced a new catalogue devoted entirely to hospital restraints. Included is a complete line of belts and straps, wristlets and anklets with slots and metal staples in both vertical and horizontal positions to provide maximum comfort; a complete line of mitts and muffs—heavy duty equipment for extreme cases, light duty items for mild restraint.

Also included are operating table wristlets and anklets with closing straps in a variety of positions, waist belts and a host of other well-designed, expertly made items incorporating the exclusive Humane Restraint locks. All units are available in a complete range of sizes.

This well edited, explicit catalogue in colour, with prices, will be sent free upon request to Humane Restraint Company, Box 16, 824 E. Johnson Street, Madison 1, Wisconsin.

Bingo Drain Pipe Opener Now in Liquid Form

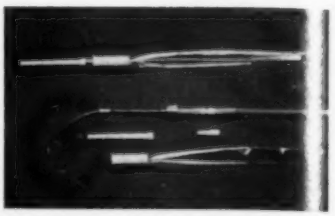
Bingo Drain Pipe Opener, an institutional stand-by for many years, is now available in liquid form. This announcement was recently made by the manufacturer, Huntington Laboratories Limited.

New Liquid Bingo Drain Pipe Opener is expected to provide greater effectiveness and handling ease for the user. The compound quickly dislodges slime, grease, hair, coffee grounds and other trouble-makers from pipes and plumbing fixtures.

For more information about this product and the complete Huntington line, write to: Huntington Laboratories Limited, 36 Parliament Street, Toronto 2, Ontario.

New Model Intracath Units of Advanced Design

A Bardic Deseret Intracath of advanced design is now available. The device, introduced last year, is used to place a pliant catheter within the vein without scrubbing, gloving or venous cutdown.



Six inch and twelve inch catheters of animal tested polyethylene, each with three needle sizes, will now augment the present Intracath line.

The new models feature a flow control plug that permits immediate regulation of blood flow, following the venipuncture. The adapter is now an integral part of the catheter to facilitate easy connection to an I.V. set. A needle bevel cover has also been added.

Disposable parts such as the needle guard, sac collar and flow control plug are colour-coded to simplify use of the Intradath.

Write C. R. Bard, Inc., Summit, New Jersey, for additional details.

Bendix and Wilmot Castle Sign Agreement

The Bendix Corporation has announced an agreement whereby Wilmot Castle Company of Rochester, New York, will be responsible for sales and distribution of the Bendix line of sonic energy cleaning systems for hospital application.

The two companies will also undertake a joint program to broaden the application of hospital sonic energy systems through research and development, according to George A. Lewthwaite, general manager of the Pioneer-Central Division of Bendix, Davenport, Iowa, and John H. Castle, Jr., President of Wilmot Castle. This program, the two company officials pointed out, will combine Bendix engineering and electronic capabilities with Wilmot Castle's long experience as a major designer and manufacturer of hospital sterilizing, lighting, and related equipment.

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